

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

01062

Reg. Dist. No. 362

1 85

1. PLACE OF DEATH COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Wash.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hagerstown		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 26 Harmon Ave.,		STREET ADDRESS (If rural, give location) 26 Harmon Ave.,	
3. NAME OF DECEASED (Type or Print)	(First) Robert	(Middle) N	(Last) Ahalt
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH Nov. 6, 1955
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY infant	9. AGE last birtbday 2 mos.xx.
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James J. Ahalt		14. MOTHER'S MAIDEN NAME Dorothy Lidie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY No. none	
17. INFORMANT AND ADDRESS James J. Ahalt Hagerstown, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Virus pneumonia		6 hrs.
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION -		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Hhmo, farm, factory, street, OF office bldg., etc.) INJURY none	(CITY OR TOWN) - (COUNTY) - (STATE) -	
TIME (Month) (Day) (Year) (Hour) OF INJURY none	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? none	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE **S. Robert M. Wells, M.D.** DEPUTY MEDICAL EXAM. ADDRESS **115 N. Potomac St- Hagerstown, Md.** DATE SIGNED **1-11-56**

23. BURIAL, CREMATION REMOVAL burial	DATE THEREOF 1-13-56	NAME OF CEMETERY OR CREMATORY Rose Hill	LOCATION (City, town, or county) Hagerstown (State) Md.
DATE REC'D BY LOCAL REG. Jan. 13, 1956	REGISTRAR'S SIGNATURE Shackelford	24. FUNERAL DIRECTOR Fred W. Kraiss	ADDRESS Hagerstown, Md.

2181266394

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 16 1966

BUREAU V. S.

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

I TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Dr. Beachley

01063

1986

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hagerstown</u>		<u>9 hrs</u>		TOWN <u>Hagerstown</u>		<u>03</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>				STREET ADDRESS (If rural give location) <u>50 East Antietam St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>BELTRAN LENNOX ALEXANDER</u>				<u>Jan. 1, 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Divorced</u>	<u>April 23, 1889</u>	<u>66</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Columbia, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Alexander</u>				14. MOTHER'S MAIDEN NAME <u>Emily Jane Broom</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-5791A</u>		17. INFORMANT & ADDRESS <u>Miss Edna Alexander</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Carcinoma of prostate</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of prostate</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of prostate</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 1953 to Aug 1956, that I last saw the deceased alive on Jan 1956, and that death occurred at Hagerstown, Md. from the causes and on the date stated above.							
SIGNATURE <u>Dr. Beachley</u>				DATE SIGNED <u>Jan 3/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 3, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Blair H. Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Md.</u>			
DATE <u>Jan 4, 1956</u>							

CERTIFICATE OF DEATH

Form No. 100

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF CLERK

21. SIGNATURE OF ASSISTANT CLERK

22. SIGNATURE OF RECEPTIONIST

23. SIGNATURE OF TELEPHONE OPERATOR

24. SIGNATURE OF MAIL ROOM

25. SIGNATURE OF RECORDS SECTION

26. SIGNATURE OF STATISTICS SECTION

27. SIGNATURE OF LABORATORY

28. SIGNATURE OF RADIOLOGY

29. SIGNATURE OF PATHOLOGY

30. SIGNATURE OF BACTERIOLOGY

31. SIGNATURE OF VIROLOGY

32. SIGNATURE OF IMMUNOLOGY

33. SIGNATURE OF EPIDEMIOLOGY

34. SIGNATURE OF PUBLIC HEALTH

35. SIGNATURE OF COMMUNITY HEALTH

36. SIGNATURE OF SCHOOL HEALTH

37. SIGNATURE OF OCCUPATIONAL HEALTH

38. SIGNATURE OF ENVIRONMENTAL HEALTH

39. SIGNATURE OF NUTRITION

40. SIGNATURE OF PHYSICAL EDUCATION

41. SIGNATURE OF RECREATION

42. SIGNATURE OF ARTS AND CRAFTS

43. SIGNATURE OF MUSIC

44. SIGNATURE OF THEATRE

45. SIGNATURE OF FILM

46. SIGNATURE OF TELEVISION

47. SIGNATURE OF RADIO

48. SIGNATURE OF PRESS

49. SIGNATURE OF LITERATURE

50. SIGNATURE OF ARTS AND CRAFTS

BUREAU V. S.

JAN 9 1956

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INSTRUCTIONS
TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

010664

1987

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Hagerstown</u>		LENGTH OF STAY (In this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>129 East Ave.,</u>				STREET ADDRESS (If rural give location) <u>129 East Ave.,</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Katie</u> (Middle) <u>Elizabeth</u> (Last) <u>Bair</u>				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>16</u> (Year) <u>19 56</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH <u>Dec. 8, 1875</u>	
				9. AGE last birthday <u>80</u> yrs.		IF UNDER 1 YEAR Months Days	
						IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>home duties</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Thomas Widdows</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Loudenslager</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Arthur E. Bair Hagerstown, Md.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Calcific Aortic Stenosis</u>						<u>8 years</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Arteriosclerotic Heart Disease</u>						<u>8 years</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cholelithiasis</u>						<u>4 1/2 years</u>	
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/> at work				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-22</u> , <u>19 48</u> , to <u>1-16-56</u> , <u>19</u> , that I last saw the deceased alive on <u>1-16</u> , <u>19 56</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dalton M. West</u>				ADDRESS (Street, city, town, state) <u>M.D. 998 Potomac Ave Hagerstown Md 1-18-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>				DATE THEREOF <u>1-19-56</u>		LOCATION (City, town, or county) (State) <u>Rose Hill Cemetery Hagerstown Md.</u>	
24. REC'D BY REGISTRAR <u>Jan. 19, 1956</u>				REGISTRAR'S SIGNATURE <u>Blair H. Powers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraiss</u>	
						ADDRESS <u>Hagerstown, Md.</u>	

CERTIFICATE OF DEATH

Form No. 10

1. NAME - RESIDENTIAL ADDRESS OF DECEASED

2. PLACE OF DEATH

3. NAME - RESIDENTIAL ADDRESS OF DECEASED

4. NAME - RESIDENTIAL ADDRESS OF DECEASED

5. NAME - RESIDENTIAL ADDRESS OF DECEASED

6. NAME - RESIDENTIAL ADDRESS OF DECEASED

7. NAME - RESIDENTIAL ADDRESS OF DECEASED

8. NAME - RESIDENTIAL ADDRESS OF DECEASED

9. NAME - RESIDENTIAL ADDRESS OF DECEASED

10. NAME - RESIDENTIAL ADDRESS OF DECEASED

11. NAME - RESIDENTIAL ADDRESS OF DECEASED

12. NAME - RESIDENTIAL ADDRESS OF DECEASED

13. NAME - RESIDENTIAL ADDRESS OF DECEASED

14. NAME - RESIDENTIAL ADDRESS OF DECEASED

15. NAME - RESIDENTIAL ADDRESS OF DECEASED

16. NAME - RESIDENTIAL ADDRESS OF DECEASED

17. NAME - RESIDENTIAL ADDRESS OF DECEASED

18. NAME - RESIDENTIAL ADDRESS OF DECEASED

19. NAME - RESIDENTIAL ADDRESS OF DECEASED

20. NAME - RESIDENTIAL ADDRESS OF DECEASED

21. NAME - RESIDENTIAL ADDRESS OF DECEASED

22. NAME - RESIDENTIAL ADDRESS OF DECEASED

23. NAME - RESIDENTIAL ADDRESS OF DECEASED

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27. NAME - RESIDENTIAL ADDRESS OF DECEASED

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40. NAME - RESIDENTIAL ADDRESS OF DECEASED

41. NAME - RESIDENTIAL ADDRESS OF DECEASED

42. NAME - RESIDENTIAL ADDRESS OF DECEASED

43. NAME - RESIDENTIAL ADDRESS OF DECEASED

44. NAME - RESIDENTIAL ADDRESS OF DECEASED

BUREAU V. S.

JAN 23 1956

RECEIVED

ENCLOSURE

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01065

1088

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Washington</i>		MARYLAND		STATE <i>md.</i>		COUNTY <i>Washington</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Hagerstown</i>		<i>30 yrs</i>		TOWN <i>Hagerstown</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>317 Liberty St.</i>				STREET ADDRESS (If rural give location) <i>317 Liberty St.</i>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Alice May Barger</i>				<i>1 24 1956</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>FEMALE</i>	<i>White</i>	<i>Single</i>	<i>MAY 12, 1909</i>	<i>46</i> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>NONE</i>		<i>NONE</i>		<i>Cumberland, Md.</i>		<i>US.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Charles Henry Barger</i>				<i>Beatrice Ray Gould</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>NO</i>		<i>NONE</i>		<i>7 Berner Ave Virginia Montgomery Hagerstown Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <i>Coronary Thrombosis</i>						<i>Immediate</i>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1/24/56</i> 19, to <i>1/24/56</i> 19, that I last saw the deceased alive on <i>1/24/56</i>, and that death occurred at <i>3:00</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>Leah F. Young</i>				ADDRESS (Street, city, town, state) <i>Williamport Md</i>		DATE SIGNED <i>1/24/56</i>	
				M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>1/27/56</i>		<i>Rest Haven Cemetery</i>		<i>Hagerstown Md.</i>	
24. READ BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>Jan. 26/56</i>		<i>Chas. H. Bowers</i>		<i>Rest Haven Funeral Chapel Inc.</i>		<i>Wm. A. Host V. Pres</i>	

1059 W. 1st St. N. 10/11

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Can be used as

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Yours

13-11-1964

Charles Henry Jones

Verdun 10/10/1918

None

2212

BUREAU V. S.

JAN 30 1956

RECEIVED

(over)

5/1/52

1999

INSTRUCTIONS

1 The law requires that the death certificate be filed within **24 hours** after death.

TO ATTENDING PHYSICIAN OF HOSPITAL: The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01066

1136

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>WASHINGTON</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>BOONSBORO</u>		<u>35 YEARS</u>		TOWN <u>BOONSBORO</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>N. MAIN ST.</u>				STREET ADDRESS (If rural give location) <u>N. MAIN ST.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>G. HERBERT BENDER</u>				<u>JANUARY-23 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>APRIL-14-1872</u>	<u>83-9-9</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>RETIRED MERCHANT-ROC. STORE</u>		<u>SITARDSBURG WASH. CO. MD.</u>		<u>U.S.A.</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>MICHAEL BENDER</u>				<u>MARY BROVILEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>NOISE</u>		<u>MISS ALEXINA BENDER Boonsboro MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>420.9</u> IMMEDIATE CAUSE (A)				<u>Arteriosclerotic heart with decompensation.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>7 yrs.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 17</u>, 19<u>55</u>, to <u>Jan 23</u>, 19<u>56</u>, that I last saw the deceased alive on <u>Jan 23</u>, 19<u>56</u>, and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>1/25/56</u>			
				ADDRESS (Street, city, town, state) <u>Boonsboro</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>BURIAL</u>		<u>JAN. 26. 1956</u>		<u>BOONSBORO CEMETERY</u>		<u>BOONSBORO WASH. CO. MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>[Signature]</u>		<u>[Signature]</u>		<u>[Signature]</u>			
DATE				ADDRESS			
<u>May 26. 1956</u>				<u>1047. Baughman Boonsboro md.</u>			

01000

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1933

Form 10-1-33

1. NAME OF DECEASED (Print or Write)

MARRIAGE

DATE

PLACE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

TEMPERATURE

PULSE

BLOOD PRESSURE

WEIGHT

HEIGHT

HAIR

EYES

TEETH

SKIN

NOSE

EARS

THROAT

STOMACH

INTESTINES

BLADDER

RECTUM

UTERUS

VAGINA

PELVIS

FEET

ANKLES

SHINS

HEELS

TOES

FINGERS

THUMB

MIDDLE

RING

SMALL

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MIDDLE

RING

SMALL

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MIDDLE

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SMALL

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MIDDLE

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SMALL

INDEX

BUREAU V. S.

JAN 30 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be filed with the registrar within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1989

CERTIFICATE OF DEATH

01067

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hagerstown</u>		<u>8 days</u>		TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>				STREET ADDRESS (If rural give location) <u>137 Elm St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>EMMA</u>		(Middle) <u>JULIA</u>		(Last) <u>BLENARD</u>		<u>Jan. 38</u> 19 <u>58</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>March 13, 1871</u>	<u>84</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Hopewell, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick Blenard</u>				14. MOTHER'S MAIDEN NAME <u>Julia Blenard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. W. Fred Blenard</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
450.1 IMMEDIATE CAUSE (A) <u>Septicemia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Gangrene arterio sclerosis of foot</u>				<u>1 month</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arterio sclerosis.</u>				<u>years.</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>1/2-156</u>		19b. MAJOR FINDINGS OF OPERATION <u>Gangrene of foot</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/6</u> , 19 <u>58</u> , to <u>1/28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/27</u> , 19 <u>58</u> , and that death occurred at <u>2:30 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edmund H. Overman M.D.</u>				ADDRESS (Street, city, town, state) <u>Hagerstown, Md.</u>		DATE SIGNED <u>1/28/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-30-58</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) <u>Hagerstown, Md.</u>	
24. REC'D BY REGISTRAR <u>Jan. 31/1958</u>		REGISTRAR'S SIGNATURE <u>Edward H. Overman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown, Md.</u>	

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01068

190

CERTIFICATE OF DEATH

Reg. Dist. No. 302

Item 9, Film G191 1-18-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Washington		STATE Maryland		COUNTY Washington			
CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown		LENGTH OF STAY (in this place) life		CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 219 Alexander St.,				STREET ADDRESS (If rural give location) 219 Alexander St.,			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Charles		(Middle) J		(Last) Boward		(Month) 1 (Day) 6 (Year) 19 56	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Jan. 21, 1894	9. AGE last birthday 61 62/ yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumberman		10b. KIND OF BUSINESS OR INDUSTRY Scott Barber		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James W. Boward				14. MOTHER'S MAIDEN NAME Helene Cline			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. 217-10-2707		17. INFORMANT & ADDRESS Ethel M. Boward Hagerstown, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
200.1 IMMEDIATE CAUSE (A) lymphosarcoma						6 mo.	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 22, 1956 , to Jan 6, 1957 , that I last saw the deceased alive on Jan 5, 1956 , and that death occurred at 4:00 P.M. from the causes and on the date stated above.							
SIGNATURE Chris J. Holman		M.D.		ADDRESS (Street, city, town, state) Hagerstown Md.		DATE SIGNED 11/7/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF 1-9-56		NAME OF CEMETERY OR CREMATORY Rest Haven		LOCATION (City, town, or county) (State) Hagerstown Md.	
24. REC'D BY REGISTRAR Jan 9, 1956		REGISTRAR'S SIGNATURE Chas. H. Boward		25. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	

CERTIFICATE OF DEATH

1. Name of deceased: **James L. Howard**

2. Date of death: **Jan. 21, 1904**

3. Place of death: **Home**

4. Age at death: **37**

5. Sex: **Male**

6. Race: **White**

7. Marital status: **Married**

8. Occupation: **Farmer**

9. Cause of death: **Heart disease**

10. Signature of physician: **John H. Howard**

11. Signature of registrar: **John H. Howard**

12. Signature of informant: **John H. Howard**

13. Signature of witness: **John H. Howard**

14. Signature of witness: **John H. Howard**

15. Signature of witness: **John H. Howard**

16. Signature of witness: **John H. Howard**

17. Signature of witness: **John H. Howard**

18. Signature of witness: **John H. Howard**

19. Signature of witness: **John H. Howard**

20. Signature of witness: **John H. Howard**

21. Signature of witness: **John H. Howard**

22. Signature of witness: **John H. Howard**

23. Signature of witness: **John H. Howard**

24. Signature of witness: **John H. Howard**

25. Signature of witness: **John H. Howard**

26. Signature of witness: **John H. Howard**

27. Signature of witness: **John H. Howard**

28. Signature of witness: **John H. Howard**

RECEIVED
JAN 19 1904
BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Washington CITY (If outside corporate limits, write RURAL or TOWN and give nearest town) Boonesboro HOSPITAL OR INSTITUTION OR STREET ADDRESS Nalley Nursing Home S. Main St		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Washington CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown STREET ADDRESS (If rural give location) 58 E. Irvin	
3. NAME OF DECEASED: (Type or Print) Elila Fanny Bower		4. DATE (Month) (Day) (Year) OF DEATH: Jan 16 1956	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH: Oct. 9, 1879
9. AGE last birthday 76 yrs.		10. IF UNDER 1 YEAR: Months Days	11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life.) Sales Lady		10B. KIND OF BUSINESS OR INDUSTRY: Dept. Store	11. BIRTHPLACE (State or foreign country): Hagerstown Md.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME: Elias F. Bower	
14. MOTHER'S MAIDEN NAME: Savil Marr		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 214-09-0726a		17. INFORMANT & ADDRESS: Mrs. Kathleen Lambros Hag. Md.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Coronary occlusion			1 hr
ANTECEDENT CAUSE (S) Coronary thrombosis			2 month
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. Coronary arteriosclerosis			Indef
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Generalized arteriosclerosis			Indef.
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 1, 1955 , to Jan 16, 1956 , that I last saw the deceased alive on Jan 13, 1956 , and that death occurred at 7:30 P M, from the causes and on the date stated above.			
SIGNATURE Paul Harrison		DATE SIGNED 318 N. Potomac Hagerstown Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1-19-56	
NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		LOCATION (City, town or county) (State) Hagerstown Md.	
DATE REC'D BY LOCAL REGISTRAR Jan 19, 1956		REGISTRAR'S SIGNATURE John D. East	
24. FUNERAL DIRECTOR Scott F. Minnich & S		ADDRESS on Hag. Md.	

01069
385

BUREAU V. S.

JAN 24 1956

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN: The law requires that the death certificate be filed with the registrar within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01070

1091

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>WASHINGTON</u> MARYLAND CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>WAGERTOWN</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WASHINGTON CO. HOSP.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>PENNA.</u> COUNTY <u>FRANKLIN</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - MERCERSBURG, PA.</u> STREET ADDRESS (If rural give location) <u>R. #1</u> <u>75X-3</u> ✓	
3. NAME OF DECEASED (First) <u>RUTH</u> (Middle) <u>SMITH</u> (Last) <u>BURKHOLDER</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>21</u> (Year) <u>1956</u>	
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>11/18/1891</u>
9. AGE last birthday <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MERCERSBURG, PA. R. 2</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DANIEL SMITH</u>		14. MOTHER'S MAIDEN NAME <u>MYRA ANGLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or rank.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT & ADDRESS <u>WALTER W. Burkholder, Mercersburg, Pa. R. 1</u>		18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>155X IMMEDIATE CAUSE (A) ADENOCARCINOMA OF GALL BLADDER AND ANTECEDENT CAUSE(S) DUE TO PANCREAS -</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>(B) NONE.</u> (C) <u> </u>	
19a. DATE OF OPERATION <u>JAN. 16, 1956</u>		19b. MAJOR FINDINGS OF OPERATION <u> </u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN.</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21e. HOW DID INJURY OCCUR?		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>DEC 17, 1955</u> , to <u>JAN 21, 1956</u> , that I last saw the deceased alive on <u>JAN 21, 1956</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Archie Robert Corn</u> M.D.		DATE SIGNED <u>1-22-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1/24/56</u>	
NAME OF CEMETERY OR CREMATORY <u>WELSH RUN BRETHERN</u>		LOCATION (City, town, or county) (State) <u>MERCERSBURG, PA. R. 2</u>	
24. REC'D BY REGISTRAR DATE <u>JAN. 23, 1956</u>		REGISTRAR'S SIGNATURE <u>Charles B. Seewer</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. Linniger</u>		ADDRESS <u>Mercersburg, Pa.</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. MARITAL STATUS
8. COLOR

9. DATE OF DEATH

10. PLACE OF DEATH
11. CAUSE OF DEATH
12. MANNER OF DEATH

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF REGISTRAR

BUREAU V. S.

JAN 21 1936

RECEIVED

1. This certificate is to be filled out by the physician or other person who has attended the deceased, or by the registrar of the health department, or by the coroner, or by the undertaker, or by the person who has taken charge of the funeral, or by the person who has taken charge of the burial, or by the person who has taken charge of the interment, or by the person who has taken charge of the cremation, or by the person who has taken charge of the other disposition of the body.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1992

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01071

Dr. Welty

CERTIFICATE OF DEATH

Item 9, Film G191 1-17-56 et

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		STATE <u>Maryland</u>		COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hagerstown</u>		<u>6 mos.</u>		TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>950 View Street</u>				STREET ADDRESS (If rural give location) <u>950 View Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>FLORENCE</u> (Middle) <u>ALNEGIA</u> (Last) <u>CLARK</u>				<u>Jan. 6,</u> <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Feb. 28, 1877</u>	<u>76</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>Hagerstown, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William H. Bowers</u>				<u>Annie C. Deihl</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>None</u>		<u>Mrs. Myra L. Martin</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						<u>5 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Arteriosclerosis</u>						<u>4 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerotic Heart Disease</u>						<u>5 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 6, 1948</u>, to <u>Jan. 6, 1956</u>, that I last saw the deceased alive on <u>Jan. 6, 1956</u>, and that death occurred at <u>2:15 PM</u>, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Saltin M. Welty</u>				<u>998 Potomas Ave. Hagerstown, Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-9-56</u>		<u>Rose Hill Cemetery</u>		<u>Hagerstown, Wash. Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>Jan. 10, 1956</u>		<u>Charles Bowers</u>		<u>Andrew K. Coffman-Hagerstown, Md.</u>			

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01072

Reg. Dist. No. 302

1093

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hagerstown</u>		<u>12 hours</u>		TOWN <u>Rural Myersville</u>		<u>10X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>				STREET ADDRESS (If rural give location) <u>Route # 2</u>			
3. NAME OF DECEASED (Type or Print) <u>EDDIE</u> <u>FLOYD</u> <u>CLINE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 28</u> <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Single</u>		8. DATE OF BIRTH <u>Sept. 30, 1888</u>	
				9. AGE last birthday <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Myersville, Fred. Co. Md. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Isiah Cline</u>				14. MOTHER'S MAIDEN NAME <u>Manzella Shank</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-16-3028</u>		17. INFORMANT & ADDRESS <u>J.J.Cline, Myersville, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
601X IMMEDIATE CAUSE (A) <u>Chronic hydronephrosis with hydro-ureters</u>						<u>Indef.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Benign prostate hypertrophy</u>						<u>Indef.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Cardiac hypertrophy and arteriosclerotic heart disease</u>						<u>Indef.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 25, 1956</u> , to <u>Jan. 28, 1956</u> , that I last saw the deceased alive on <u>Jan. 28, 1956</u> , and that death occurred at <u>11:55</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>148 West Washington St. Hagerstown, Maryland</u>		DATE SIGNED <u>Jan. 30, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 31, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>St. Paul's Lutheran</u>		LOCATION (City, town, or county) <u>Myersville, Md.</u>	
24. REC'D BY REGISTRAR <u>Feb. 1, 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Paul F. Bittle, Myersville, Md.</u>			

1. The first part of the document is a letter from the author to the editor, dated 19th March 1964. The letter is signed 'Yours faithfully, [illegible]'. The letter is addressed to the editor of the 'Journal of the Royal Society of Medicine'.

FEB 3 1956

RECEIVED

1094

Reg. Dist. 01073

No. 302

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <u>Hagerstown</u>				TOWN <u>Hagerstown</u>			
HOSPITAL, OR INSTITUTION OR STREET ADDRESS <u>143 W. Washington St.</u>				STREET ADDRESS (If rural, give location) <u>8 Marbern Road</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Elizabeth</u>		(Middle) <u>JANE</u>		(Last) <u>COLE</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>12/8/24</u>	
				9. AGE last birthday: <u>31</u> yrs.		4. DATE OF DEATH (Month) (Day) (Year) <u>1 2 1956</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Medical</u>		11. BIRTHPLACE (State or foreign country): <u>Washington</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Fred M. Cole</u>				14. MOTHER'S MAIDEN NAME: <u>Pauline G. Marber</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>270-16-2397</u>		17. INFORMANT & ADDRESS: <u>Fred M. Cole 7 Marbern Rd. Hagerstown, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<p>3533</p> <p>Immediate cause (a) <u>Died suddenly during epileptic convulsion</u></p> <p style="text-align: center;">DUE TO</p> <p>Antecedent cause(s) (b) <u>giving rise to the above cause stating underlying cause last</u></p> <p style="text-align: center;">DUE TO</p> <p>(c)</p>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>None</u>		19b. MAJOR FINDING OF OPERATION: <u>-</u>				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>--</u>			
<p>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .</p> <p>SIGNATURE <u>J. P. Kelly & Wells</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Jan. 3-56</u></p> <p>DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/></p>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF: <u>1/5/56</u>		NAME OF CEMETERY OR CREMATORY: <u>Rest Haven Cem</u>		LOCATION (City, town, or county) (State): <u>HAGERSTOWN Md.</u>	
DATE REC'D BY LOCAL REG. <u>Jan. 5, 1956</u>		REGISTRAR'S SIGNATURE: <u>Blair H. Bowers</u>		24. FUNERAL DIRECTOR: <u>Rest Haven Funeral Chapel Inc.</u>		ADDRESS:	

BUREAU V. S.

JAN 9 1955

RECEIVED

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1138 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01074

CERTIFICATE OF DEATH

Reg. Dist. No. 301

Item 9, Film G191 1-17-56 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>W.V.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Martinsburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Williamsport Sanatorium</u>		<u>3 months</u>		STREET ADDRESS (If rural give location) <u>608 Faulkner Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Helen Coleman</u>				<u>January 10, 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE (Type or Print)	MARRIED (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.
<u>female</u>	<u>white</u>			<u>April 3 1892</u>	<u>63</u> yrs.	<u>72</u> Months	<u>72</u> Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
						<u>Middleway, W.Va.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Luther Ring</u>				<u>Lina Shipa</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give way or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						<u>Henry Coleman, Martinsburg, W.Va.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.0</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) DUE TO <u>Cerebral Vascular Accident</u>						<u>3 hrs.</u>	
(B) DUE TO <u>Hypertensive Arteriosclerotic Heart Disease</u>						<u>2 yrs.</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October</u> , 19 <u>55</u> , to <u>Jan 10, 1956</u> that I last saw the deceased alive on <u>3 Jan</u> , 19 <u>56</u> , and that death occurred at <u>8:00</u> A. M., from the causes and on the date stated above.							
SIGNATURE <u>Claverbach</u>				DATE SIGNED <u>10 Jan 56</u>			
M. D. <u>Williamsport, Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/10/56</u>		<u>Rose Dale</u>		<u>Martinsburg W.Va.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Jan 10 - 56</u>		<u>C Lee McElroy</u>		<u>Howard K. Brown</u>			

BUREAU V. 3

JAN 12 1956

RECEIVED

NOV 22 1955

1139

MARYLAND STATE DEPARTMENT OF HEALTH

01075

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 302 ³⁰⁵

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Boonsboro</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hagerstown R.F.D. # 1</u>		STREET ADDRESS (If rural, give location) <u>R. F. D. # 2</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>RICHARD</u>	(Middle) <u>FRANKLIN</u>	(Last) <u>COSENS</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>January 1, 1938</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>18</u> yrs. <u>0</u> Months <u>14</u> Days
11. BIRTHPLACE (State or foreign country) <u>Boonsboro Rt. 2, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles H. Cosens Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Jane C. Muck</u>	
15. WAS DECEASED EVEN IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-34-5591</u>	
17. INFORMANT AND ADDRESS <u>Charles H. Cosens Boonsboro Rt. 2 Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

8222X
Immediate cause(a) Fractured skull - hemorrhage and shock

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

none

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>	PLACE (Home, farm, factory, street, office bldg, etc.) INJURY <u>Highway</u>	(CITY OR TOWN) <u>Rural - Mt. Lena Rd-</u>	(COUNTY) <u>Wash.</u>	(STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY - <u>15-56 @ 7:30P</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Passenger in auto that upset</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

DEPUTY MEDICAL EXAM.

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/18/1956</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown, Maryland</u>	(State)
DATE REC'D BY LOCAL REG <u>Jan. 17, 1956</u>	REGISTRAR'S SIGNATURE <u>John D. East</u>	24. FUNERAL DIRECTOR <u>Suter-Rouzer Funeral Home</u>		
		ADDRESS <u>Hagerstown, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. R.

JAN 23 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1095

1. PLACE OF DEATH: COUNTY Washington MARYLAND CITY (If outside corporate limits, write RURAL or TOWN) Hagerstown LENGTH OF STAY (in this place) 60 years HOSPITAL OR INSTITUTION OR STREET ADDRESS 57 W. Washington St.		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Washington CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown STREET ADDRESS (If rural give location) 57 W. Washington St.	
3. NAME OF DECEASED: (Type or Print) Charles Winton Cromer		4. DATE (Month) (Day) (Year) OF DEATH: Jan 15 1956	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: March 2, 1874
9. AGE last birthday: 81 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, retired or owner) Mill Owner		10B. KIND OF BUSINESS OR INDUSTRY: Hosiery	
11. BIRTHPLACE (State or foreign country): State Line Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: John Cromer		14. MOTHER'S MAIDEN NAME: Amanda Duffy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY No. 220-18-2079	
17. INFORMANT & ADDRESS: Mrs. Margaret E. Cromer Hag. Md.			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 332x IMMEDIATE CAUSE (A) Cerebral Thrombosis ANTECEDENT CAUSE (S) DUE TO (B) Cerebral Arteriosclerosis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			INTERVAL BETWEEN ONSET AND DEATH 4 wk. 4 yr.
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug. 19, 1956 , to Jan. 15, 1956 , that I last saw the deceased alive on Jan. 14, 1956 , and that death occurred at 1:45 A.M. from the causes and on the date stated above. SIGNATURE [Signature] ADDRESS Hagerstown, Maryland DATE SIGNED Jan. 1956 M. D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1-17-56	
NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		LOCATION (City, town, or county) (State) Hagerstown Md.	
DATE REC'D BY LOCAL REGISTRAR Jan. 17, 1956		REGISTRAR'S SIGNATURE [Signature]	
24. FUNERAL DIRECTOR Scott F. Minnich & Son		ADDRESS Hag. Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 19 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 302

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Washington		MARYLAND		STATE Md		COUNTY Washington	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Hagerstown		LENGTH OF STAY (in this place) 38 yrs.		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Hagerstown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Co. Hospital				STREET ADDRESS (If rural, give location) 900 Mulberry Ave.			
3. NAME OF DECEASED: (Type or Print) Harry		(First) Stine		(Middle) Crunkleton		(Last)	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed		8. DATE OF BIRTH: Dec. 18, 1872	
9. AGE last birthday: 83 yrs.		4. DATE OF DEATH: Jan 19 19 56		9. AGE last birthday: 83 yrs.		IF UNDER 1 YEAR: Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Assembler		10b. KIND OF BUSINESS OR INDUSTRY: Organ		11. BIRTHPLACE (State or foreign country): Franklin County Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: David L. Crunkleton				14. MOTHER'S MAIDEN NAME: Sarah J. Stine			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: H. Preston Crunkleton		Hag. Md.	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) DUE TO Fractured(closed) skull					
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO hemorrhage & shock				17 hrs.	
stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. aortic stenosis					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home		21c. (City or town) (County) (State) 900 Mulberry Ave- Hagerstown, Wash. Md.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 1-19-56 2:30PM		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Fell off back porch	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE S. Robert M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-20-56	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 1-22-56		NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	
LOCATION (City, town, or county) (State) Hagerstown Md.		24. FUNERAL DIRECTOR Scott F. Minnich & Son		ADDRESS Hag. Md.	
DATE REC'D BY LOCAL REG. Jan. 21, 1956		REGISTRAR'S SIGNATURE [Signature]			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 24 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Dr Weeks

01078

1097

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>20 Yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>18 So. Cannon Ave</u>				STREET ADDRESS (If rural give location) <u>18 So Cannon Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>MERLE VAN LEAR DEIBERT</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>January 6 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 8 1908</u>	9. AGE last birthday <u>47</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pipe fitter</u>		11. BIRTHPLACE (State or foreign country) <u>Cavetown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hezekiah Deibert</u>				14. MOTHER'S MAIDEN NAME <u>Mary Burger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-10-7449</u>		17. INFORMANT & ADDRESS <u>Mrs Irene C. Deibert</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
430.1 IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis & Anemia</u>						<u>22 1/2 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from on <u>1/6</u> , 19 <u>56</u> , to <u>1/6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/6</u> , 19 <u>56</u> , and that death occurred at <u>3 a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS (Street, city, town, state) <u>136 N. Potomac, Hagerstown, Md.</u>			
DATE <u>Jan. 10. 1956</u>				DATE SIGNED <u>1/6/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/8/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
24. READ BY REGISTRAR <u>Jan. 10. 1956</u>		REGISTRAR'S SIGNATURE <u>Phyllis Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>			
DATE				ADDRESS <u>Hagerstown Md.</u>			

1. This form is to be filled out by the attending physician or other qualified person who has attended the deceased. It should be filled out as soon as possible after death, and should be submitted to the health department as soon as possible. It is a legal document and should be filled out truthfully and accurately. It is the responsibility of the attending physician or other qualified person to ensure that the information provided is correct and complete. The information provided on this form will be used for statistical purposes and to help the health department understand the causes of death and the health of the community. It is important that the information provided is accurate and complete, as it will be used to make decisions about public health and to help prevent future deaths.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1901

1. Name of deceased (Print name and full name)

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Date of death

7. Time of death

8. Cause of death (Print cause of death)

9. Place of death

10. Signature of attending physician

11. Signature of registrar

12. Date of registration

13. Time of registration

14. Signature of registrar

15. Signature of registrar

16. Signature of registrar

17. Signature of registrar

18. Signature of registrar

19. Signature of registrar

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59. Signature of registrar

60. Signature of registrar

BUREAU V. 1

RECEIVED
JAN 13 1901

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OF HOSPITAL:** The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1998

CERTIFICATE OF DEATH

01079

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>5 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Home</u>				STREET ADDRESS (If rural give location) <u>1490 PENNSYLVANIA AVE</u>			
3. NAME OF DECEASED (Type or Print) <u>FLORENCE EUGENIA DIFFENDERFER</u>				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>24</u> (Year) <u>1998</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>7/7/1872</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Clark Co. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Carpenter</u>				14. MOTHER'S MAIDEN NAME <u>JANE WILDA GRIFFITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>158 S. Potomac St. Leroy Diffenderfer Hagerstown, MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
151X IMMEDIATE CAUSE (A) <u>CARCINOMA OF STOMACH</u>						INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>RHEUMATOID ARTHRITIS</u>						<u>UNKNOWN</u>	
19a. DATE OF OPERATION <u>NONE</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JUNE 20, 1953</u> , to <u>JAN. 24, 1956</u> , that I last saw the deceased alive on <u>JAN. 24, 1956</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Archie Robert Cohen M.D.</u>				ADDRESS (Street, city, town, state) <u>CLEAR SPRING MD</u>		DATE SIGNED <u>1/25/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/27/56</u>		NAME OF CEMETERY OR CREMATORY <u>Old Chapel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Boyce, Va.</u>	
24. REC'D BY REGISTRAR <u>Jan. 26, 1956</u>		REGISTRAR'S SIGNATURE <u>Wm. A. Herst</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>REST HAVEN FUNERAL CHAPEL INC.</u>		ADDRESS <u>Wm. A. Herst V.PRES.</u>	

1842-1843

most complete

1880-1881

Fluorine: 24.1

1/1/1815 1815

Thomas W. Clark Co. Virginia

Joseph Carpenter June 18. 1890

None

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4426

[Faint handwritten notes]

BUREAU V. S.

AN 30 1956

2000

1/27/20 Old Chapel Cemetery

1955

1000

Dr. Warden
832 8th Ave.

BUREAU V. S.

JAN 31 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 01081

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Washington	MARYLAND	STATE Md.	COUNTY Washington
CITY (If outside corporate limits, write RURAL OR TOWN) Hagerstown	LENGTH OF STAY (If in this place) 4 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1845 Jefferson Blvd.		STREET ADDRESS (If rural give location) 1845 Jefferson Blvd.	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
Margaret Lacie Dubel		Jan 9 1956	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH: Jan. 25, 1883
9. AGE last birthday 72 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurses Aide		10B. KIND OF BUSINESS OR INDUSTRY: Hospital	
11. BIRTHPLACE (State or foreign country): Baltimore Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Charles Wooden		14. MOTHER'S MAIDEN NAME: Mary Kone	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 214-29-8812	
17. INFORMANT & ADDRESS: Mrs. Clara Bohrer Hag. Md.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Portal Cirrhosis with Splenomegaly			7 mo.
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B)			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerosis Obliterans, Lower			2 mo.
19A. DATE OF OPERATION: 0	19B. MAJOR FINDINGS OF OPERATION Extremities with Gangrene		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 20 1955 , to Jan. 9, 1956 , that I last saw the deceased alive on Jan. 8, 1956 , and that death occurred at 5:30 AM , from the causes and on the date stated above.			
SIGNATURE [Signature]		ADDRESS Hagerstown, Md.	DATE SIGNED Jan. 11, 1956
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 1-11-56	NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	LOCATION (City, town, or county) (State) Hagerstown Md.
DATE REC'D BY LOCAL REGISTRAR Jan. 11, 1956	REGISTRAR'S SIGNATURE [Signature]	24. FUNERAL DIRECTOR ADDRESS Scott F. Minnich & Son Hag. Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 13 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

01082

1101

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ALONG MD. R. 40</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>WASHINGTON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PBA AT HOSPITAL</u>				STREET ADDRESS (If rural, give location) <u>4707 BAYARD BLVD - WASH. 16 D.C.</u>			
3. NAME OF DECEASED (First)		(Middle)		(Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>EDWIN</u>		<u>CLYDE</u>		<u>DUVALL</u>		<u>JANUARY - 6 - 1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year		If under 24 hrs
<u>MALE</u>	<u>WHITE</u>	<u>SINGLE</u>	<u>APRIL - 9 - 1882</u>	<u>73 - 8 - 27 yrs.</u>	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
						<u>MYERSVILLE FRED Co. MD.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>MARCELLUS DUVALL</u>				<u>CORNELIA STOTTLEMYER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS	
<u>No.</u>						<u>MRS J. K. SHERWOOD 4707 BAYARD BLVD. WASH. 16 D.C.</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Fractured Skull - Hemorrhage & Shock</u>						<u>15 min</u>	
Antecedent cause(s) (b) <u>Fracture rt. & lt. tibia & fibula</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. EXTERNAL CAUSE WAS PRIMARY (or CONTRIBUTING) <input type="checkbox"/> PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Highway</u>				(CITY OR TOWN) (COUNTY) (STATE) <u>U S # 40 - East - Hagerstown Wash Md</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Jan - 6 56 6P.m.</u>				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
				HOW DID INJURY OCCUR? <u>Struck by car while walking on highway</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .							
SIGNATURE <u>S. P. Wells M.D. DEPUTY MEDICAL EXAM.</u>				DATE SIGNED <u>Jan. 8 - 56</u>			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>JAN. 9. 1956</u>		<u>UNITED BRETHREN CEMETERY</u>		<u>MYERSVILLE FRED. Co. MD</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Jan. 9. 1956</u>		<u>Wm. F. Bast</u>		<u>Wm. F. BAST AND SONS</u>		<u>BOONSBORO MD</u>	

RECEIVED

JAN 12 1956

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01083

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Washington		MARYLAND		STATE Maryland		COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown		LENGTH OF STAY (in this place) 50 yrs		CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 34 Avalon Ave.,				STREET ADDRESS (If rural give location) 34 Avalon Ave.,			
3. NAME OF DECEASED (Type or Print) Lauretta Easton				4. DATE OF DEATH (Month) 1 (Day) 6 (Year) 19 56			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH Sept. 2, 1875	9. AGE last birthday 80 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Chewsville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Dibert				14. MOTHER'S MAIDEN NAME Elizabeth Hoover			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Edgar A. Easton Hagerstown, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) Arteriosclerotic heart disease						2 yrs	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None.							
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 9, 1955, to Dec. 6, 1956, that I last saw the deceased alive on Dec. 6, 1956, and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
SIGNATURE <i>Ka B. Lee</i>		M. D.		ADDRESS (Street, city, town, state) Hagerstown, Maryland		DATE SIGNED Dec. 8, 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF 1-9-56		NAME OF CEMETERY OR CREMATORY Rose Hill		LOCATION (City, town, or county) (State) Hagerstown Md.	
24. REC'D BY REGISTRAR DATE Jan. 10, 1957		REGISTRAR'S SIGNATURE <i>Paul H. Powers</i>		25. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	

PHOTOGRAPH

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C.
This is to certify that the following is a true and correct copy of the photograph of the person named above, as taken by the United States Department of Justice, Federal Bureau of Investigation, on the date and at the place indicated below.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

NAME OF DECEASED Washington Hagerstown		AGE 20 YRS		SEX Male		RACE White		DATE OF DEATH 1-2-26		PLACE OF DEATH Hagerstown, Md.	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		DISEASE OR INJURY None		PREVIOUS ILLNESS None		TIME OF DEATH 10:00 AM		PLACE OF BURIAL Hagerstown, Md.	
NAME OF DECEASED Jacob Elmer		AGE 70 YRS		SEX Male		RACE White		DATE OF DEATH 1-2-26		PLACE OF DEATH Hagerstown, Md.	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		DISEASE OR INJURY None		PREVIOUS ILLNESS None		TIME OF DEATH 10:00 AM		PLACE OF BURIAL Hagerstown, Md.	
NAME OF DECEASED John A. Hager		AGE 70 YRS		SEX Male		RACE White		DATE OF DEATH 1-2-26		PLACE OF DEATH Hagerstown, Md.	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		DISEASE OR INJURY None		PREVIOUS ILLNESS None		TIME OF DEATH 10:00 AM		PLACE OF BURIAL Hagerstown, Md.	

BUREAU V. S.

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1103

CERTIFICATE OF DEATH

01084

Reg. Dist. No. 302

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY WASHINGTON	MARYLAND	STATE MARYLAND	COUNTY WASHINGTON
CITY (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	LENGTH OF STAY (in this place) LIFE	CITY (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 38 S. MULBERRY ST.	STREET ADDRESS (If rural give location) 38 S. MULBERRY ST.		
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) EVA ELIZABETH ELIAS		4. DATE OF DEATH (Month) (Day) (Year) JANUARY 14 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, WEDDED	8. DATE OF BIRTH 3/22/1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	9. AGE last birthday 67 yrs.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN GRIFFITH		14. MOTHER'S MAIDEN NAME CATHERINE BURGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) NO		16. SOCIAL SECURITY NO. 214-09-1330	
17. INFORMANT & ADDRESS MRS. DOROTHY MARINO		HAGERSTOWN MD.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) Myocardial Infarction			2 days
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Coronary Arteriosclerotic Heart Disease			1 1/2 years
(C) Hypertensive Cardiovascular Disease			1 1/2 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 28, 19 54, to January 14, 19 56, that I last saw the deceased alive on January 14, 19 56 and that death occurred at 6:00 P.M., from the causes and on the date stated above.			
SIGNATURE <i>Dellin M. Walty</i> M.D.		ADDRESS (Street, city, town, state) DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	DATE THEREOF 1/17/56	NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	LOCATION (City, town, or county) (State) HAGERSTOWN MD.
24. REC'D BY REGISTRAR DATE Jan 18, 1956	REGISTRAR'S SIGNATURE <i>Shasth Bowers</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>W. J. Normant, Hagerstown, Md.</i>	

CERTIFICATE OF DEATH

See Dist. No.

1. Name of deceased (Print or Write)

2. Date of death (Print or Write)

3. Place of death (Print or Write)

4. Cause of death (Print or Write)

5. Date of death (Print or Write)

6. Place of death (Print or Write)

7. Cause of death (Print or Write)

8. Date of death (Print or Write)

9. Place of death (Print or Write)

10. Cause of death (Print or Write)

11. Date of death (Print or Write)

12. Place of death (Print or Write)

13. Cause of death (Print or Write)

14. Date of death (Print or Write)

15. Place of death (Print or Write)

16. Cause of death (Print or Write)

17. Date of death (Print or Write)

18. Place of death (Print or Write)

19. Cause of death (Print or Write)

20. Date of death (Print or Write)

21. Place of death (Print or Write)

22. Cause of death (Print or Write)

23. Date of death (Print or Write)

24. Place of death (Print or Write)

25. Cause of death (Print or Write)

26. Date of death (Print or Write)

27. Place of death (Print or Write)

28. Cause of death (Print or Write)

29. Date of death (Print or Write)

30. Name of deceased (Print or Write)

31. Date of death (Print or Write)

32. Place of death (Print or Write)

33. Cause of death (Print or Write)

34. Date of death (Print or Write)

35. Place of death (Print or Write)

36. Cause of death (Print or Write)

37. Date of death (Print or Write)

38. Place of death (Print or Write)

39. Cause of death (Print or Write)

40. Date of death (Print or Write)

41. Place of death (Print or Write)

42. Cause of death (Print or Write)

43. Date of death (Print or Write)

44. Place of death (Print or Write)

45. Cause of death (Print or Write)

46. Date of death (Print or Write)

47. Place of death (Print or Write)

48. Cause of death (Print or Write)

49. Date of death (Print or Write)

50. Place of death (Print or Write)

51. Cause of death (Print or Write)

52. Date of death (Print or Write)

53. Place of death (Print or Write)

54. Cause of death (Print or Write)

55. Date of death (Print or Write)

56. Place of death (Print or Write)

57. Cause of death (Print or Write)

58. Date of death (Print or Write)

BUREAU A. 2

AN 28 1956

RECEIVED

DEPARTMENT OF HEALTH

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01085

1104

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hagerstown, Md.</u>		<u>53 yrs</u>		TOWN <u>Hagerstown, Maryland.</u>		<u>03</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>107 W Bethel Street</u>				STREET ADDRESS (If rural give location) <u>107 W. Bethel Street.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Nellie Irene Francis</u>				<u>1 23 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>Colored</u>	<u>Single</u>	<u>April 26 1899</u>	<u>56</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Domestic</u>		<u>Private family</u>		<u>Beaver Creek, Md.</u>		<u>USA.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Waltz</u>				<u>Fannie Francis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>215-20-8893</u>		<u>Mrs Bessie Snowden</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>331X</u> IMMEDIATE CAUSE (A)				<u>Cerebral vascular accident</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>sudden</u>			
				<u>years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 18 1956, to Jan 23 1956, that I last saw the deceased alive on Jan 18 1956, and that death occurred at 5:30 PM, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Dr. N. W. S. K. S. M.D. 136 N. Potomac Hagerstown Md</u>				<u>1-23-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-26-1956</u>		<u>Rose Hill Cemetery</u>		<u>Hagerstown, Maryland.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Jan 27 1956</u>		<u>John R. Watson</u>		<u>John R. Watson</u>		<u>Hagerstown Md</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BOSTON

1. NATAL RESIDENCE (INDICATE IF CHANGED)

2. PLACE OF DEATH

3. PLACE OF BIRTH

4. DATE OF BIRTH

5. SEX

6. OCCUPATION

7. CAUSE OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. PLACE OF BIRTH

12. DATE OF BIRTH

13. SEX

14. OCCUPATION

15. CAUSE OF DEATH

16. DATE OF DEATH

17. TIME OF DEATH

18. PLACE OF DEATH

19. PLACE OF BIRTH

20. DATE OF BIRTH

21. SEX

22. OCCUPATION

23. CAUSE OF DEATH

24. DATE OF DEATH

25. TIME OF DEATH

26. PLACE OF DEATH

27. PLACE OF BIRTH

28. DATE OF BIRTH

29. SEX

30. OCCUPATION

31. CAUSE OF DEATH

32. DATE OF DEATH

33. TIME OF DEATH

34. PLACE OF DEATH

35. PLACE OF BIRTH

36. DATE OF BIRTH

37. SEX

38. OCCUPATION

39. CAUSE OF DEATH

40. DATE OF DEATH

41. TIME OF DEATH

42. PLACE OF DEATH

43. PLACE OF BIRTH

44. DATE OF BIRTH

45. SEX

46. OCCUPATION

47. CAUSE OF DEATH

48. DATE OF DEATH

49. TIME OF DEATH

49. PLACE OF DEATH

50. PLACE OF BIRTH

51. DATE OF BIRTH

52. SEX

53. OCCUPATION

54. CAUSE OF DEATH

55. DATE OF DEATH

56. TIME OF DEATH

57. PLACE OF DEATH

58. PLACE OF BIRTH

59. DATE OF BIRTH

60. SEX

61. OCCUPATION

62. CAUSE OF DEATH

63. DATE OF DEATH

64. TIME OF DEATH

65. PLACE OF DEATH

66. PLACE OF BIRTH

67. DATE OF BIRTH

68. SEX

69. OCCUPATION

70. CAUSE OF DEATH

71. DATE OF DEATH

72. TIME OF DEATH

73. PLACE OF DEATH

74. PLACE OF BIRTH

75. DATE OF BIRTH

76. SEX

77. OCCUPATION

78. CAUSE OF DEATH

79. DATE OF DEATH

80. TIME OF DEATH

81. PLACE OF DEATH

82. PLACE OF BIRTH

83. DATE OF BIRTH

84. SEX

85. OCCUPATION

86. CAUSE OF DEATH

87. DATE OF DEATH

88. TIME OF DEATH

89. PLACE OF DEATH

90. PLACE OF BIRTH

91. DATE OF BIRTH

92. SEX

93. OCCUPATION

94. CAUSE OF DEATH

95. DATE OF DEATH

96. TIME OF DEATH

97. PLACE OF DEATH

98. PLACE OF BIRTH

99. DATE OF BIRTH

100. SEX

101. OCCUPATION

102. CAUSE OF DEATH

103. DATE OF DEATH

104. TIME OF DEATH

105. PLACE OF DEATH

106. PLACE OF BIRTH

107. DATE OF BIRTH

108. SEX

109. OCCUPATION

110. CAUSE OF DEATH

111. DATE OF DEATH

112. TIME OF DEATH

113. PLACE OF DEATH

114. PLACE OF BIRTH

115. DATE OF BIRTH

116. SEX

117. OCCUPATION

118. CAUSE OF DEATH

119. DATE OF DEATH

120. TIME OF DEATH

121. PLACE OF DEATH

122. PLACE OF BIRTH

BUREAU V. S.

JAN 30 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY WASHINGTON		MARYLAND		STATE MARYLAND		COUNTY WASHINGTON	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HAGERSTOWN		LENGTH OF STAY (In this place) 44 YRS.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HAGERSTOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 932 CHESTNUT ST.				STREET ADDRESS (If rural give location) 932 CHESTNUT ST.			
3. NAME OF DECEASED (Type or Print) (First) WILLIAM (Middle) STEINER (Last) GREEN				4. DATE OF DEATH (Month) (Day) (Year) JANUARY 7 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH 3/20/1873	9. AGE last birthday 82 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if REGULAR ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEWIS U. GREEN				14. MOTHER'S MAIDEN NAME NAOMI STEINER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. 705-10-7641		17. INFORMANT & ADDRESS Mrs. NELLIE B. GREEN		HAGERSTOWN MD.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE (A)				Pneumonia		10 days	
ANTECEDENT CAUSE(S) DUE TO				Cerebral Thrombosis.		2 year	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				Arteriosclerosis, general		years-	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 28, 1955, to Jan 7, 1956, that I last saw the deceased alive on Jan 7, 1956, and that death occurred at 4:00 P.M. from the causes and on the date stated above.							
SIGNATURE Chas. H. Hester		M.D. Hagerstown Md		ADDRESS (Street, city, town, state)		DATE SIGNED 1/9/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 1/10/56		NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
24. REC'D BY REGISTRAR DATE Jan. 10, 1956		REGISTRAR'S SIGNATURE B. H. Hester		25. FUNERAL DIRECTOR'S SIGNATURE W. J. Hornum		ADDRESS Hagerstown, Md	

ENCLOSURE

RECEIVED
JAN 23 1915
BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

NAME OF DECEASED JAMES H. HARRIS		AGE 45		SEX Male		RACE White		DATE OF DEATH Jan 20 1915	
PLACE OF BIRTH Baltimore, Md		OCCUPATION Clerk		EDUCATION High School		RELIGION Methodist		MANNER OF DEATH Natural	
CAUSE OF DEATH Heart Disease		DISEASE OR INJURY Myocardial Infarction		SYMPTOMS Chest pain, shortness of breath		TREATMENT Medical		POST-MORTEM None	
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF WITNESSES J. H. Harris, J. H. Harris		SIGNATURE OF DECEASED J. H. Harris		SIGNATURE OF NEXT OF KIN J. H. Harris		SIGNATURE OF REGISTRAR J. H. Harris	
DATE OF REGISTRATION Jan 23 1915		PLACE OF REGISTRATION Baltimore, Md		OFFICE OF REGISTRATION Baltimore, Md		OFFICE OF HEALTH Baltimore, Md		OFFICE OF VITALS Baltimore, Md	

1106

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Big Springs Md. RFD #1</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>				STREET ADDRESS (If rural give location) <u>Big Springs RFD #1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Janice Elizabeth Gruber</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 1</u> 19 <u>56</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Baby</u>	8. DATE OF BIRTH: <u>May 12 1955</u>	9. AGE last birthday yrs. <u>7</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Howard Gruber</u>				14. MOTHER'S MAIDEN NAME: <u>Annie Estep Gruber</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) <u>No</u>		17. INFORMANT & ADDRESS: <u>Big Springs RFD 1</u> <u>Mr. Howard Gruber Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Broncho Pneumonia</u>						<u>27 hours</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 31, 1955</u> to <u>Jan. 1, 1956</u> that I last saw the deceased alive on <u>Jan. 1, 1956</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>David R. Brewer</u>		M. D. <u>Clear Spring Md.</u>		DATE SIGNED <u>1/2/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 4-56</u>		NAME OF CEMETERY OR CREMATORY <u>Clearspring Cemetery</u>		LOCATION (City, town, or county) (State) <u>Near Clearspring Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan. 2, 1956</u>		REGISTRAR'S SIGNATURE <u>Edith V. Leaf</u>		24. FUNERAL DIRECTOR ADDRESS <u>Edith V. Leaf Williamsport Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 5 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1140

CERTIFICATE OF DEATH

01088

Reg. Dist. No. 307

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Washington		STATE Maryland		COUNTY Washington			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Yarrowsburg		40 yrs.		TOWN Yarrowsburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Residence				STREET ADDRESS Reed Road			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) SUSIE (Middle) ELIZABETH (Last) HANES				(Month) Jan. (Day) 27, (Year) 19 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Widow	May 3, 1894	61 yrs.	Months 8	Days 24	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Weverton, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas A. Sullivan				14. MOTHER'S MAIDEN NAME Ella Mae Fouch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mr. Glen Hanes Box 64, Knoxville, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
151X IMMEDIATE CAUSE (A) Carcinoma				Carcinoma Stomach		6 wks?	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 1-7-56		19b. MAJOR FINDINGS OF OPERATION Carcinoma Stomach		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 15, 1956, to Jan 27, 1956, that I last saw the deceased alive on Jan 27, 1956, and that death occurred at 10:30 AM, from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i> M.D.				ADDRESS (Street, city, town, state) Brownsville, Md		DATE SIGNED 1-28-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1/29/56		NAME OF CEMETERY OR CREMATORY Brethren Cemetery		LOCATION (City, town, or county) Brownsville, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		ADDRESS Harpers Ferry, West Virginia	
DATE 1/31/56							

CERTIFICATE OF DEATH

Form 100-10

1. LOCAL HEALTH OFFICE OF REGISTRATION

2. COUNTY OF BALTIMORE

3. CITY OF BALTIMORE

4. STREET

5. APARTMENT

6. DATE OF DEATH

7. TIME

8. PLACE

9. CAUSE

10. MANNER

11. SEX

12. AGE

13. NAME OF DECEASED

14. NAME OF SURVIVOR

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF DECEASED

17. SIGNATURE OF SURVIVOR

Handwritten signature

1-7-11

BUREAU V. S.

FEB 2 1956

RECEIVED

RECEIVED

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film 0192 2-7-56 et

Item 9 again: film G195 4-9-56L

01089

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Washington</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Fredrick</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Fredericktown</i>	LENGTH OF STAY (in this place) <i>14 days</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Brunswick</i>	<i>10-25-2</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Valley's Nursing Home</i>		STREET ADDRESS (If rural give location) <i>525 West Prince Street</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>Edward</i>	(Middle) <i>L.</i>	(Last) <i>Harrison</i>	(Month) <i>1</i> (Day) <i>20</i> (Year) <i>1956</i>
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <i>9-12-18-77</i>
9. AGE last birthday: <i>78</i> yrs.		10. AGE last birthday: <i>85</i> yrs.	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Samuel Harrison</i>		14. MOTHER'S MAIDEN NAME: <i>Catharine Vento</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT'S ADDRESS: <i>Mr. Earl Leach, Brunswick Md</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Generalized arteriosclerosis</i>			<i>5 yr</i>
ANTECEDENT CAUSE (S) DUE TO (B) <i>Bangrene</i>			<i>2 months</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan 6</i> , 19 <i>56</i> , to <i>Jan 20</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Jan 4</i> , 19 <i>56</i> , and that death occurred at <i>7 A</i> M, from the causes and on the date stated above.			
SIGNATURE <i>W. Wilson</i>		DATE SIGNED <i>1/20/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1-22-56</i>	
NAME OF CEMETERY OR CREMATORY <i>Harper</i>		LOCATION (City, town, or county) (State) <i>Harper Ferry W. Va.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Jan. 28, 1956</i>		REGISTRAR'S SIGNATURE <i>B. H. H. H. H. H.</i>	
24. FUNERAL DIRECTOR		ADDRESS <i>C. A. Lull + Co Brunswick Md.</i>	

BUREAU V. B.

JAN 31 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01090

1142

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Washington		STATE Md.		COUNTY Washington			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Clearspring		LENGTH OF STAY (in this place) life		CITY (If outside corporate limits, write RURAL and give nearest town) Clearspring			
TOWN Clearspring				TOWN Clearspring			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 1				STREET ADDRESS (If rural give location) Route 1			
3. NAME OF DECEASED (First) (Middle) (Last) John Henry Hastings				4. DATE OF DEATH (Month) (Day) (Year) 1 25 1956			
5. SEX male		6. COLOR OR RACE white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married		8. DATE OF BIRTH July 3, 1883	
				9. AGE last birthday 72 yrs.		IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY farmer		11. BIRTHPLACE (State or foreign country) Indian Springs, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Thomas A. Hastings				14. MOTHER'S MAIDEN NAME Lucinda Martin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Mrs. Lottie Hastings Clearspring, Md. R1			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
200.1 IMMEDIATE CAUSE (A) LYMPHOSARCOMA, RETROPERITONEAL						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. NONE							
19a. DATE OF OPERATION APRIL 11, 1955		19b. MAJOR FINDINGS OF OPERATION AS ABOVE				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from APRIL 9, 1955, to JANUARY 25, 1956, that I last saw the deceased alive on JAN 19, 1956, and that death occurred at 10-05A.M. from the causes and on the date stated above.							
SIGNATURE <i>Adrian H. Rowland</i> M.D.				ADDRESS (Street, city, town, state) CLEAR SPRING, MARYLAND		DATE SIGNED 1-26-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF 1-27-56		NAME OF CEMETERY OR CREMATORY Blairs Valley Ch of God		LOCATION (City, town, or county) (State) Blairs Valley Md.	
24. REC'D BY REGISTRAR DATE JAN 28-1956		REGISTRAR'S SIGNATURE <i>Joseph W. Murray</i>		25. FUNERAL DIRECTOR'S SIGNATURE Adrian H. Rowland		ADDRESS Clear Spring, Md.	

1143

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Washington</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		STATE <u>Penna</u> COUNTY <u>Franklin</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u>	
TOWN <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>3 weeks</u>		STREET ADDRESS (If rural give location) <u>44 W. 4th. St.</u>		75X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Gateway Convalescent Home Hagerstown Oct 2 Mch</u>							
3. NAME OF DECEASED: (First) <u>OLIVER</u> (Middle) <u>NORRIS</u> (Last) <u>HAUGH</u>				4. DATE OF DEATH: (Month) <u>JAN</u> (Day) <u>28</u> (Year) <u>1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married Jan 28 Oct 27, 1879</u>		8. DATE OF BIRTH: <u>76 yrs.</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William J. Haugh</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Linah</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Norris B. Haugh Baltimore Md</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Acute Cardiac Failure</u>		<u>Sudden</u>
Antecedent causes (b) <u>Carcinoma of Prostate Gland</u>		<u>4 yrs</u>
(c)		

II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>	
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <u>Jan 6, 1956</u> , to <u>Jan 28, 1956</u> , that I last saw the deceased alive on <u>Jan 27, 1956</u> , and that death occurred at <u>3:15 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>David J. Brewer M.D. Clear Spring Md.</u>		DATE SIGNED <u>1/28/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>1/31/1956</u>	
NAME OF CEMETERY OR CREMATORY <u>BURNS HILL CEMETERY</u>		LOCATION (City, town, or county) (State) <u>WAYNESBORO, PENNA.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb-1-56</u>		REGISTRAR'S SIGNATURE <u>Leroy M. Finkler (Deputy)</u>	
24. FUNERAL DIRECTOR <u>H. Martin Poe</u>		ADDRESS <u>WAYNESBORO, PENNA.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 7 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1144

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Clearspring</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural-Clearspring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RD1-Clearspring, Md</u>				STREET ADDRESS (If rural, give location) <u>RD1-Clearspring, Md.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Phares</u> <u>Strite</u> <u>Horst</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>Jan</u> <u>30</u> <u>1956</u>			
5. SEX: <u>m</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH: <u>5/2/1885</u>	9. AGE last birthday: <u>70</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Abra Ham Horst</u>				14. MOTHER'S MAIDEN NAME: <u>Catherine Strite</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs. Carrie Horst - Clearspring, Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause		(a) <u>Coronary Embolysm</u>				<u>Sudden</u>	
Antecedent cause(s)		(b) <u>Hypertrophy of Prostate Gland</u>				<u>3 yrs.</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c) <u>Stone in Bladder</u>				<u>3 weeks</u>	
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>Jan 16, 1956</u>		19b. MAJOR FINDINGS OF OPERATION: <u>Stones in Bladder, Hypertrophic Prostate</u>					
20. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		CITY OR TOWN		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not while work at work		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 15, 1955</u> , to <u>Jan 30, 1956</u> , that I last saw the deceased alive on <u>Jan 30, 1956</u> , and that death occurred at <u>4:50 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>David H. Brewer M.D.</u>				ADDRESS <u>Clearspring Md.</u>		DATE SIGNED <u>2/1/56</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (city, town, or county) (State)	
<u>Burial</u>		<u>2/3/1956</u>		<u>Clearspring Cem.</u>		<u>Clearspring Md.</u>	
DATE REC'D BY LOCAL REG		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Feb 1 - 1956</u>		<u>Joseph W. Murray</u>		<u>W. E. Munnich</u>		<u>Greencastle Pa.</u>	

BUREAU V. S.

FEB 6 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wash Co.</u> MARYLAND	CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Williamsport, Md.</u>	STATE <u>Md.</u> COUNTY <u>Wash Co.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chemsville</u>
TOWN <u>Williamsport</u>	LENGTH OF STAY (in this place) <u>4 yrs.</u>	TOWN <u>Chemsville</u>	STREET ADDRESS (If rural give location) <u>154 N. Artisan St.</u>
3. NAME OF DECEASED: (Type or Print) <u>Ida Virginia Houch</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan 20 1956</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>unmarried</u>	8. DATE OF BIRTH: <u>Dec 30 1869</u>
9. AGE last birthday <u>86</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): <u>Chemsville, Md.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME: <u>David Spessard</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Elizabeth Zentmyer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Lutie Remsburg Hagerstown Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>			<u>6 mo.</u>
ANTECEDENT CAUSE (S) <u>Cerebral Arteriosclerosis</u>			<u>5 yr.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <u>Terminal Bronchial Pneumonia</u>			<u>5 days</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 19, 1956</u> , to <u>Jan. 20, 1956</u> that I last saw the deceased alive on <u>Jan. 19, 1956</u> , and that death occurred at <u>9:08 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		M. D. <u>Hagerstown, Maryland</u> DATE SIGNED <u>Jan. 20 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-23-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan. 21, 1956</u>		REGISTRAR'S SIGNATURE <u>E Lee McElroy</u>	
24. FUNERAL DIRECTOR <u>Scott F. Minnich & Son Hag.</u>		ADDRESS <u>Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 26 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy, of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01094

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY WASHINGTON MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN OR TOWN LIFE HOSPITAL OR INSTITUTION OR STREET ADDRESS WASHINGTON COUNTY HOSPITAL				2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY WASHINGTON CITY (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN OR TOWN 1142 SECURITY RD. STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) EDWARD ELWOOD HULL				4. DATE OF DEATH (Month) (Day) (Year) JANUARY 20 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH 3/9/1933	9. AGE last birthday 22 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY GENERAL WORK		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CLARENCE E. HULL				14. MOTHER'S MAIDEN NAME LULA B. PURDHAM			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. 220-28-9100		17. INFORMANT & ADDRESS MR. CLARENCE HULL		HAGERSTOWN MD.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 590X IMMEDIATE CAUSE (A) Acute Glomerular nephritis ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) STATING UNDERLYING CAUSE LAST. DUE TO (C)				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 wks	
19a. DATE OF OPERATION 0				19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 19th 1956 , to Jan 20th 1956 , that I last saw the deceased alive on Jan 19th 1956 , and that death occurred at 2nd M., from the causes and on the date stated above. SIGNATURE Thos J. Holliman M.D. Hagerstown Md ADDRESS (Street, city, town, state) 1/24/56 DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 1/22/56		NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
24. REC'D BY REGISTRAR Jan. 23, 1956		REGISTRAR'S SIGNATURE Phyllis Bowers		25. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md			

BUREAU V. S.

JAN 25 1956

RECEIVED

BUREAU V. S.

JAN 9 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01096

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY WASHINGTON MARYLAND CITY (If outside corporate limits, write RURAL OR TOWN) HAGERSTOWN 55 YRS. HOSPITAL OR INSTITUTION OR STREET ADDRESS ARLOCK MEM. CONV. HOSPITAL				2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY WASHINGTON CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HAGERSTOWN STREET ADDRESS (If rural give location) 44 1/2 E. FRANKLIN ST.			
3. NAME OF DECEASED (Type or Print) (First) DAVID (Middle) HENRY (Last) JONES			4. DATE OF DEATH (Month) (Day) (Year) JAN. 11 19 56				
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 11/17/1881	9. AGE last birthday 74 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BRAKEMAN		10b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD	11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME JAMES LEWIS JONES			14. MOTHER'S MAIDEN NAME MARY R. SWINK				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unk.) NO		16. SOCIAL SECURITY NO. 705-09-7657	17. INFORMANT & ADDRESS MR. CLYDE M. JONES HAGERSTOWN MD.				
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
260x IMMEDIATE CAUSE (A) Coronary Thrombosis				INTERVAL BETWEEN ONSET AND DEATH 3 days			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerosis				Yrs.			
(C) Diabetes Mellitus				5 yrs.			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from JAN 8 , 19 56 , to JAN 11 , 19 56 , that I last saw the deceased alive on JAN 11 , 19 56 , and that death occurred at 11:55 P.M. from the causes and on the date stated above. SIGNATURE Clayton A. Hoffman M.D. 214 N. Potomac St. - Hagerstown, Md. 4/1/6 ADDRESS (Street, city, town, state) DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 1/14/56		NAME OF CEMETERY OR CREMATORY Rest Haven CEM.			
24. REC'D BY REGISTRAR DATE JAN. 16 1956		REGISTRAR'S SIGNATURE Clayton A. Hoffman		25. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant ADDRESS Hagerstown, Md.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 19 1956

RECEIVED

1. This certificate is to be filled out by the attending physician or the coroner, and is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland. It is to be filled out in duplicate, and the original is to be filed in the office of the Registrar, and the duplicate is to be filed in the office of the attending physician or the coroner. It is to be filled out in duplicate, and the original is to be filed in the office of the Registrar, and the duplicate is to be filed in the office of the attending physician or the coroner.

NAME OF DECEASED JAMES LEWIS JONES		PLACE OF BIRTH WASHINGTON, D.C.	
DATE OF BIRTH 10-09-1884		SEX M	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
PLACE OF DEATH BALTIMORE, MD.		DATE OF DEATH 1-18-56	
SIGNATURE OF PHYSICIAN J. E. JONES		SIGNATURE OF CORONER J. E. JONES	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1146
Dr. L. Graff

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01097

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		STATE <u>Maryland</u>		COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hagerstown R#2</u>		<u>2 mos.</u>		TOWN <u>Hagerstown R#2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Greencastle Pike</u>				STREET ADDRESS (If rural give location) <u>Greencastle Pike</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>CATHERINE LOUISE KROBOTH</u>				<u>Jan. 22, 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>March 29, 1955</u>	<u>10</u> yrs. <u>23</u> months <u>23</u> days	<u>10</u> Months <u>23</u> Days	<u>10</u> Hours <u>23</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Infant</u>		<u>None</u>		<u>Hagerstown, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Frank Kroboth</u>				<u>Lula Bell Barger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mr. Frank Kroboth</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>085.1</u> IMMEDIATE CAUSE (A) <u>Cardiovascular collapse</u>						<u>min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pneumonia</u>						<u>3 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Measles.</u>						<u>4 days prev</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 29, 19 55</u>, to <u>Jan. 22, 19 56</u>, that I last saw the deceased alive on <u>Jan. 22, 19 56</u>, and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Louis S. Graff</u> M.D.				<u>119 E. Antietam St. 1-23-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-24-56</u>		<u>Rose Hill Cemetery</u>		<u>Hagerstown, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>Jan. 25, 1956</u>		<u>Blair H. Bowers</u>		<u>Andrew K. Coffman-Hagerstown, Md.</u>			

1081 213344

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01098

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		STATE <u>Md.</u>		COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hagerstown</u>		<u>37 yrs.</u>		TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>124 East Ave.,</u>				STREET ADDRESS (If rural give location) <u>124 East Ave.,</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Delilah</u> (Middle) <u>Hann</u> (Last) <u>Krout</u>				(Month) <u>1</u> (Day) <u>30</u> (Year) <u>56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>female</u>	<u>white</u>	<u>WIDOWED</u>	<u>May 9, 1887</u>	<u>68</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>housewife</u>		<u>own home</u>		<u>Frederick Co. Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George Hann</u>				<u>Julia Clem</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>217-432-5593</u>		<u>Helma Hann Bowers Frederick, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>211X</u> IMMEDIATE CAUSE (A) <u>Pulmonary embolism.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Post-operative. (Ilio-colostomy)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>None.</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
<u>Jan. 9, 1956.</u>		<u>Villous papilloma of cecum.</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at home <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 3, 1956</u> to <u>Jan. 30, 1956</u>, that I last saw the deceased alive on <u>Jan. 30, 1956</u>, and that death occurred at <u>9:00A</u> from the causes and on the date stated above.							
SIGNATURE <u>Ka. Bell</u>				DATE SIGNED <u>Jan. 30, 1956</u>			
				ADDRESS (Street, city, town, state) <u>119 N. Potomac St. Hagerstown, Md. 1-30-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>2-1-56</u>		<u>Creagerstown</u>		<u>Creagerstown Fred. Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>M.L. Creager & Son</u> ADDRESS <u>Thurmont, Md.</u>			
<u>DATE 3 1956</u>		<u>Chas. H. Bowers</u>					

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

Death Date: Feb. 3, 1956

NAME William V. S.		SEX Male		RACE White		DATE OF BIRTH Nov. 9, 1927		PLACE OF BIRTH Baltimore, Md.		USUAL RESIDENCE 124 East Ave., Baltimore, Md.		PLACE OF DEATH Baltimore, Md.		CAUSE OF DEATH Heart Disease	
MARRIAGE Single		OCCUPATION None		RELIGION Catholic		EDUCATION High School		SERVICE None		SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)		SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CLERK (None)		SIGNATURE OF REGISTRAR (None)		SIGNATURE OF JUDGE (None)		SIGNATURE OF SHERIFF (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)		SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CLERK (None)		SIGNATURE OF REGISTRAR (None)		SIGNATURE OF JUDGE (None)		SIGNATURE OF SHERIFF (None)		SIGNATURE OF CORONER (None)	

214-32-5593

BUREAU V. S.

FEB 3 1956

RECEIVED

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased, or by the coroner or other qualified person who has examined the body.

2. The certificate should be filled out as soon as possible after death, and should be filed in the office of the registrar of vital statistics.

3. The certificate should be filled out in duplicate, and one copy should be filed in the office of the registrar of vital statistics, and the other copy should be filed in the office of the coroner or other qualified person who has examined the body.

4. The certificate should be filled out in the English language, and should be signed by the physician or other qualified person who has attended the deceased, or by the coroner or other qualified person who has examined the body.

5. The certificate should be filled out in the English language, and should be signed by the physician or other qualified person who has attended the deceased, or by the coroner or other qualified person who has examined the body.

CERTIFICATE OF DEATH

Reg. Dist. No. 300

1147

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Washington	MARYLAND	STATE Maryland	COUNTY Washington
CITY (If outside corporate limits, write RURAL OR and give nearest town) Sharpshurg Md.	LENGTH OF STAY (in this place) 89 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) Sharpshurg Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 220 West Main Street	STREET ADDRESS (If rural give location) 220 West Main Street		
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) Lillie	(Middle) M	(Last) Lakin	(Month) Jan (Day) 9 (Year) 1956
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: Nov. 17 1866
9. AGE last birthday: 89 yrs.		10. AGE last birthday: 1 Months 22 Days 1 Hours 1 Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY: Home	
11. BIRTHPLACE (State or foreign country): Sharpshurg Md.		12. CITIZEN OF WHAT COUNTRY: USA	
13. FATHER'S NAME: Jack Delauney		14. MOTHER'S MAIDEN NAME: Louisa Hammond	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS: 220 West Main St. Mrs. Hilda Mose Sharpshurg Md.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Generalized arteriosclerosis			5 Yr
ANTECEDENT CAUSE (S) Senility			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from 1950 , 19..., to Jan. 9 , 19 56 , that I last saw the deceased alive on 1/6/56 , 19..., and that death occurred at 1:45 P M, from the causes and on the date stated above.			
SIGNATURE [Signature]		DATE SIGNED 1/11/56	
23. BURIAL, CREMATION, REMOVA (SPECIFY) Burial		DATE THEREOF Jan. 12-56	
NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		LOCATION (City, town, or county) (State) Sharpshurg Md.	
DATE REC'D BY LOCAL REGISTRAR 1-12-56		REGISTRAR'S SIGNATURE [Signature]	
24. FUNERAL DIRECTOR Albert L. Leaf		ADDRESS Williamport Md.	

BUREAU V. S.

JAN 18 1956

RECEIVED

1111

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

COUNTY Washington MARYLAND
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY
 OR and give nearest town) 10 days
 TOWN Hagerstown
 HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS Washington Co. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Wash.
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR
 TOWN Smithsburg X
 STREET (If rural give location)
 ADDRESS E. Water St. /

3. NAME OF DECEASED:

(First) (Middle) (Last)
Carrie Virginia Law
 (Type or Print)

4. DATE OF DEATH: (Month) (Day) (Year)
Jan. 16 19 56

5. SEX:

female

6. COLOR OR RACE:

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH:

June 14, 1877

9. AGE last birthday:

78 yrs.

10. IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

house wife

10b. KIND OF BUSINESS OR INDUSTRY:

own home

11. BIRTHPLACE (State or foreign country):

Washington County, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

William T. Slick

14. MOTHER'S MAIDEN NAME:

Ann Masters

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
no

16. SOCIAL SECURITY No.:

--

17. INFORMANT & ADDRESS:

Mrs. E. Pauline Law, Smithsburg, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Generalized Arteriosclerosis

Interval Between Onset And Death

14 days

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
 OF INJURY

m.

INJURY OCCURRED

While at Work ☐Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from 1/2, 1956, to 1/16, 1956, that I last saw the deceased

alive on 1/16, 1956, and that death occurred at 9:30 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Charles E. Hess

M.D.

Smithsburg, Md.

1/17/56

23. BURIAL, CREMATION, REMOVAL (Specify)

burial

DATE THEREOF

1-19-56

NAME OF CEMETERY OR CREMATORY

Smithsburg Cemetery

LOCATION (City, town, or county)

Smithsburg, Md.

(State)

DATE REC'D BY LOCAL REGISTRAR

Jan. 19, 1956

REGISTRAR'S SIGNATURE

Blair Bowers

24. FUNERAL DIRECTOR

Scott F. Minnich & Son, Smithsburg

ADDRESS

BUREAU V. S.

JAN 23 1956

RECEIVED

1 INSTRUCTIONS TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01101

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CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Washington		MARYLAND		STATE Pa.		COUNTY Franklin	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Hagerstown		6 Wks		TOWN Rural Waynesboro		75X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
Jacksn Nursing Home				Waynesboro #4			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Lillian (Middle) Monroe (Last) Layman				(Month) Jan. 2, (Day) 1956 (Year)			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Married	Sept. 27, 1878	77 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		House Wife		Near Myersville, Fred. Co.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Lewis Flook				Margaret Warnfeltz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No				Charles D. Layman, Waynesboro Pa. #4			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
260X IMMEDIATE CAUSE (A)				Coronary occlusion			
ANTECEDENT CAUSE(S) DUE TO				Arteriosclerosis & Diabetes			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				suddenly			
				years			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 55, to Dec 55, that I last saw the deceased alive on Dec 55, and that death occurred at 4 AM, from the causes and on the date stated above. 1/3/56							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
Howard A. Woods		M.D.		PO Box 2, Hagerstown Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, county) (State)	
Burial		1/6/56		Green Hill		Waynesboro, Franklin Pa.	
24. READ BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Jan. 4, 1956		G. H. Bowers		Walter J. Grove, Waynesboro Pa.			

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

011102

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CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		STATE <u>Maryland</u> COUNTY <u>Washington</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Hagerstown, Maryland</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Hagerstown, Maryland</u>		CITY OR TOWN <u>Hagerstown, Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hosp.</u>		STREET ADDRESS (If rural give location) <u>125 W. Church Street</u>		STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print) <u>Herman Thomas Lewis</u>				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>26</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>May 28 1955</u>	9. AGE last birthday yrs. <u>8</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Herman T. Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Florence Stone</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Herman T. Lewis. 125 W Church St.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
539.1 IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Tracheo-esophageal fistula & trauma of esophagus.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Gastrostomy</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/25</u> , 19 <u>56</u> , to <u>1/26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/24</u> , 19 <u>56</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
SIGNATURE <u>D. M. Bocan Jr.</u>		M.D. <u>30271-Potomac Hagerstown, Md.</u>		DATE SIGNED <u>1/28/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-29-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>	
24. REC'D BY REGISTRAR <u>John R. Watson</u>		REGISTRAR'S SIGNATURE <u>John R. Watson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Watson</u>		ADDRESS <u>Hagerstown, Md.</u>	

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FEB 1 1956

RECEIVED

1148

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>WASHINGTON</u> MARYLAND				STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>CLEVELANDVILLE</u>		<u>9 YEARS</u>		TOWN <u>CLEVELANDVILLE - RURAL</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>BOONSBORO MD. R.2</u>				STREET ADDRESS (If rural give location) <u>BOONSBORO MD. R.2.</u>			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
<u>ELIZABETH</u>		<u>LONG</u>		DATE OF DEATH <u>JANUARY-10-1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>JULY-31-1865</u>	<u>90-6-9 yrs.</u>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSE KEEPER</u>		<u>OWN HOME</u>		<u>ROUZERVILLE PENNA</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>NO RECORD</u>				<u>NO RECORD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>NO</u>		<u>NONE</u>		<u>MRS. LILLIAN LONG BOONSBORO MD. R.2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
450.0 IMMEDIATE CAUSE (A) <u>Generalized arteriosclerosis</u>						<u>5 yrs</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
M.							
22. I hereby certify that I attended the deceased from <u>Jan 10</u> , 19 <u>56</u> , to <u>Jan 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 10</u> , 19 <u>56</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>L. E. Williams</u>				ADDRESS <u>Boonsboro</u>		DATE SIGNED <u>1/11/56</u>	
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>JANUARY-13-1956</u>		<u>BOONSBORO CEMETERY</u>		<u>BOONSBORO WASH. Co. MD</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Jan 11, 1956</u>		<u>John C. Baird</u>		<u>WM. F. BAST AND SONS</u>		<u>BOONSBORO MD</u>	

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JAN 18 1936

RECEIVED

1114

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: COUNTY WASHINGTON MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) HAGERSTOWN TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS 116 MANSE RD.		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY WASHINGTON CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HAGERSTOWN STREET ADDRESS (If rural give location) 116 MANSE RD.	
3. NAME OF DECEASED: (Type or Print) (First) JULIUS (Middle) AMBROSE (Last) MANN		4. DATE (Month) (Day) (Year) OF DEATH: JAN. 26 19 56	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH: 6/11/1887
9. AGE last birthday 68 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life.) RETIRED FARMER		10B. KIND OF BUSINESS OR INDUSTRY: TENNANT FARMER	11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME: DAVID MANN	
14. MOTHER'S MAIDEN NAME: MARY CREEK		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) (If Yes, give war or dates of service) NO	
16. SOCIAL SECURITY No. 215-26-0927A		17. INFORMANT & ADDRESS: MRS. BERTHA MANN HAGERSTOWN MD.	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 332X IMMEDIATE CAUSE (A) Cerebral Thrombosis ANTECEDENT CAUSE (S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) _____ (C) _____			INTERVAL BETWEEN ONSET AND DEATH 3 mo.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pulvic ulcer			years
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov , 19 55 , to 26/12 , 19 56 , that I last saw the deceased alive on 21/12 , 19 56 , and that death occurred at 6:00 M, from the causes and on the date stated above. SIGNATURE E. J. Edwards M. D. Hagerstown DATE SIGNED 1/27/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1/28/56	
NAME OF CEMETERY OR CREMATORY Rox Hill Cem. Hagerstown Md.		LOCATION (City, town, or county) (State) Md.	
DATE REC'D BY LOCAL REGISTRAR Jan 27 1956		REGISTRAR'S SIGNATURE W. J. Norman	
24. FUNERAL DIRECTOR W. J. Norman		ADDRESS Hagerstown Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 30 1956

RECEIVED

1115

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Washington	MARYLAND	STATE Md.	COUNTY Washington
CITY (If outside corporate limits, write RURAL OR TOWN) Hagerstown	LENGTH OF STAY (in this place) 65 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 710 Summit Ave		STREET ADDRESS (If rural give location) 710 Summit Ave	
3. NAME OF DECEASED: (First) Ella (Middle) Appel (Last) Miller		4. DATE (Month) (Day) (Year) OF DEATH: Jan 30 1956	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: Feb. 7, 1867
9. AGE last birthday 88 yrs.		10. BIRTHPLACE (State or foreign country): Cumberland Md.	
11. USUAL OCCUPATION (Give kind of work done during most of working life.) House Wife		12. CITIZEN OF WHAT COUNTRY? Own Home	
13. FATHER'S NAME: John Appel		14. MOTHER'S MAIDEN NAME: Caroline Hetzel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT & ADDRESS: Mrs. Mary M. Clevenger Hag. Md.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) 420.0 Anteriosclerotic Heart Disease		3 yrs	
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO			
STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 18, 1955 , to Jan. 30, 1956 , that I last saw the deceased alive on Jan. 14, 1956 , and that death occurred at 4 A. M. from the causes and on the date stated above.			
SIGNATURE Robert Vh Campbell		DATE SIGNED 145 W. Wash. St. Hagerstown Md. 1/30/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2-1-56	
NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		LOCATION (City, town, or county) (State) Hagerstown Md.	
DATE REC'D BY LOCAL REGISTRAR Jan. 31, 1956		REGISTRAR'S SIGNATURE Phed Howers	
24. FUNERAL DIRECTOR Scott F. Minnich & Son		ADDRESS Hag. Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 2 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01106

1116

Dr. Lusby

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Hagerstown</u>				TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>				STREET ADDRESS (If rural give location) <u>1107 Corbett Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>JOSEPHINE ARELLA MOORE</u>				<u>Jan. 10, 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>May 12, 1886</u>	<u>69</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Matron</u>		<u>Fairchild</u>		<u>Hagerstown, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Samuel Craley</u>				<u>Josephine Fouke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>214-09-9455</u>		<u>Mrs. Ruth M. Long - 1800 Penna. Ave /</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion (1st attack)</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Occlusion (2nd attack)</u>						<u>4 y ago</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						<u>1 1/2 hrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>None</u>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 15, 19 50</u>, to <u>10 Jan, 19 56</u>, that I last saw the deceased alive on <u>10 Jan, 19 56</u>, and that death occurred at <u>11:40 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		DATE SIGNED		ADDRESS (Street, city, town, state)			
<u>J F Lusby</u>		<u>230 W Potomac St</u>		<u>Hagerstown Md 10 Jan 56</u>			
		M.D.		LOCATION (City, town, or county) (State)			
		<u>1-13-56</u>		<u>Hagerstown, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-13-56</u>		<u>Rest Haven Cemetery</u>		<u>Hagerstown, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>Jan. 12, 1956</u>		<u>W H Bowers</u>		<u>Andrew K. Coffman-Hagerstown, Md.</u>			

BUREAU V. S.

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY WASHINGTON	MARYLAND	STATE MARYLAND	COUNTY WASHINGTON
CITY (If outside corporate limits, write RURAL OR and give nearest town) HAGERSTOWN	LENGTH OF STAY (in this place) 1 1/2 YRS.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HAGERSTOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS WASHINGTON COUNTY HOSP.		STREET ADDRESS (If rural give location) 816 MARSHALL ST.	
3. NAME OF DECEASED: (First) WALTER (Middle) JACOB (Last) NEEDY NEADY		4. DATE (Month) (Day) (Year) OF DEATH: JAN. 25 19 56	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED	8. DATE OF BIRTH: 5/6/1881
9. AGE last birthday: 74 yrs.		IF UNDER 1 YEAR: Months 8 Days 19	IF UNDER 24 HRS.: Hours 19 Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED CARPENTER		10B. KIND OF BUSINESS OR INDUSTRY: SELF EMP.	
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: JACOB NEEDY/ Neady		14. MOTHER'S MAIDEN NAME: ELIZABETH WYANT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, NO or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. 367-10-9132	
17. INFORMANT & ADDRESS: MRS. RUTH RODEFFER		HAGERSTOWN MD.	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(A) IMMEDIATE CAUSE: Cerebral Vascular Accident		5 yrs.
(B) ANTECEDENT CAUSE (S): Arteriosclerosis, generalized		
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST: cerebral thrombosis		10 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Benign prostatic hypertrophy		15 yrs.
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 12, 1956 to Jan. 25, 1956 , that I last saw the deceased alive on Jan. 25, 1956 , and that death occurred at 10:18 P.M. from the causes and on the date stated above.			
SIGNATURE Edward W. Dittus III		M. D. 217 W. Washington St. 1/27/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 1/30/56	NAME OF CEMETERY OR CREMATORY Monk View Cem. Muskegon, Michigan	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REGISTRAR Jan. 27, 1956	REGISTRAR'S SIGNATURE Charles H. Powers	24. FUNERAL DIRECTOR W. J. Korman	ADDRESS Hagerstown, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 30 1956

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1149

CERTIFICATE OF DEATH

Dr Brewer

Reg. Dist. No. 01107

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Clear Spring</u>		<u>4 Yrs</u>		TOWN <u>Clear Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1 60 Main St</u>				STREET ADDRESS (If rural give location) <u>160 Main St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>JACOB HENRY NEEDY</u>				<u>Jan 17 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Dec 4 1867</u>	<u>88</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>Retired</u>		<u>Beaver Creek Md.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Isaac Needy</u>				<u>Katherine Griffey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mrs Elizabeth Y. Needy</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>421.4</u> IMMEDIATE CAUSE (A) <u>Endocardial Sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Sclerosis</u>						<u>3 weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<input type="checkbox"/>							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 23 1954</u>, to <u>Jan 17 1956</u>, that I last saw the deceased alive on <u>Jan 16 1956</u>, and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>David R. Brewer</u> M.D.		<u>Clear Spring Md.</u>		<u>1/18/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)			
<u>Burial</u>	<u>1-20-56</u>	<u>St Pauls Cemetery</u>		<u>near Clear Spring Wash. Co</u>			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				
<u>Jan 19 1956</u>	<u>Joseph W. Murray</u>		<u>Andrew K. Coffman</u> <u>Hagerstown Md.</u>				

CERTIFICATE OF DEATH

011119

Form 100-1-10

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF CORONER

16. SIGNATURE OF JURY

17. SIGNATURE OF JUDGE

18. SIGNATURE OF CLERK

19. SIGNATURE OF DEPUTY CLERK

20. SIGNATURE OF ASSISTANT CLERK

21. SIGNATURE OF CHIEF CLERK

22. SIGNATURE OF DEPUTY CHIEF CLERK

23. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK

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BUREAU V. S.

JAN 24 1956

RECEIVED

RECEIVED
JAN 24 1956
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 300

1150

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Washington		MARYLAND		STATE Maryland		COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Sharpsburg Md. RFD		42 yrs.		OR TOWN Sharpsburg Md. RFD			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Antietam Furnace				STREET ADDRESS (If rural give location) Antietam Furnace			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
Leo Ernest Otzelberger				OF DEATH: Jan. 14 19 56			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Married	April 25-1913	42 yrs.	8 Months 19 Days	Hours	Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Electrician		Victor Products		Sharpsburg Md RFD		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Walter S. Otzelberger				Elsie May Gray			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
No		No		Sharpsburg Md. RFD			
		214-16-1107		Mrs. Mary Otzelberger			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE							
(A) Malignant Essential hypertension						1 yr.	
ANTECEDENT CAUSE (S)							
(B) Cerebral Haemorrhage							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
0						YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 14 , 19 54 , to Jan 14 , 19 56 , that I last saw the deceased alive on Jan 14 , 19 56 , and that death occurred at 11:30 P. M, from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
W. L. Williams		Bornstein		11/16/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Jan. 18-56		Mt. View Cemetery		Sharpsburg Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Jan 18 1956		E. H. Boyer		Albert L. Leaf		Williamsport Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 24 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1151

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

011110

Reg. Dist. No. 304

1. PLACE OF DEATH- COUNTY Washington		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Wash	
CITY (If outside corporate limits, write RURAL and give nearest town) Rural R # 2		CITY (If outside corporate limits, write RURAL and give nearest town) Hancock	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home		STREET ADDRESS R # 2	
3. NAME OF DECEASED (Type or Print) George		4. DATE OF DEATH (Month) (Day) (Year) Jan. 9 1956	
5. SEX Male		6. COLOR OR RACE White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single		8. DATE OF BIRTH Oct. 3, 1893	
9. AGE last birthday 62 yrs.		10. If under 1 year Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Washington County		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George R Pelton		14. MOTHER'S MAIDEN NAME Mary A Coffman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY No. W.VA.2	
17. INFORMANT AND ADDRESS Mrs Addie L. Lauchart Berkeley Springs		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 Immediate cause (a) Arterio sclerotic myocardial heart disease Antecedent cause(s) (b) coronary thrombosis Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death. Chronic cystitis -diverticulum of bladder		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. TIME (Month) (Day) (Year) (Hour) OF INJURY none		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY none	
INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR? none	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE J. Robert Myers M.D.		DATE SIGNED Jan. 10 '56	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 1-12-56	
NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery		LOCATION (City, town, or county) (State) Hagerstown, Maryland	
DATE REC'D BY LOCAL REG. 1-12-56		24. FUNERAL DIRECTOR Howard J. Stone Hancock Md	

BUREAU V. E.

JAN 17 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

011111

1152

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Washington		MARYLAND		STATE Md.		COUNTY Wash.	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Smithsburg		LENGTH OF STAY (in this place) 30 years.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Smithsburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS W. Water St.				STREET ADDRESS (If rural give location) W. Water St.			
3. NAME OF DECEASED: (First) (Middle) (Last) Lulu Elgin Perry				4. DATE (Month) (Day) (Year) OF DEATH: Jan. 30 1956			
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: Sept. 6, 1875	9. AGE last birthday 80 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): teacher		10B. KIND OF BUSINESS OR INDUSTRY: public schools		11. BIRTHPLACE (State or foreign country): Prince George Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: William M. Clark				14. MOTHER'S MAIDEN NAME: Mary Elgin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY NO. - -		17. INFORMANT & ADDRESS: Jessie Mason Clark, Washington Co. Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 420.0							
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) Chronic Occlusion						30 Hour	
(B) Certain Sclerotic Heart						10 yr	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 28, 1956 , to Jan 30, 1956 , that I last saw the deceased alive on Jan 30, 1956 , and that death occurred at 3 A M. from the causes and on the date stated above. SIGNATURE G. G. K. Kofler ADDRESS Smithsburg DATE SIGNED 1/30/56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF 2-1-56		NAME OF CEMETERY OR CREMATORY St. Marks Parish Ceme.		LOCATION (City, town, or county) (State) Petersville, Md.	
DATE REC'D BY LOCAL REGISTRAR Jan 30-56		REGISTRAR'S SIGNATURE Geo W Ferguson		24. FUNERAL DIRECTOR Scott F. Minnich & Son, Smithsburg		ADDRESS	

BUREAU V. S.

FEB 3 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1118

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01112

Dr. D. Brewer

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>1 week</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Gateway Nursing Home</u>				STREET ADDRESS (If rural give location) <u>406 Summit Ave.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>OSCAR MILTON REICHARD</u> (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 14, 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb. 19 1871</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sect.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Y.M.C.A.</u>		11. BIRTHPLACE (State or foreign country) <u>Fairplay, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David W. Reichard</u>				14. MOTHER'S MAIDEN NAME <u>Alice Mary Coffman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-18-1286</u>		17. INFORMANT & ADDRESS <u>Val B. Reichard</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Acute Coronary Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Cataracts (both eyes) Arteriosclerosis</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 7, 1956</u> , to <u>Jan 14, 1956</u> , that I last saw the deceased alive on <u>Jan 13, 1956</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>David D. Brewer</u> M.D.				ADDRESS (Street, city, town, state) <u>Clear Spring Md.</u> DATE SIGNED <u>1/14/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-16-56</u>		NAME OF CEMETERY OR CREMATORY <u>Manor Cemetery</u>		LOCATION (City, town, or county) (State) <u>Nr. Tilghmanton, Md.</u>	
24. REC'D BY REGISTRAR <u>Jan 16-56</u>		REGISTRAR'S SIGNATURE <u>Ernest M. Fochler</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Md.</u>			

(1444444)

CERTIFICATE OF DEATH

Reg. No. 18-1-10

MEDICAL HISTORY HOME OR HOSPITAL

MARYLAND
DEPARTMENT OF HEALTH
BALTIMORE

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. MARRIAGE DATE		8. MARRIAGE PLACE		9. OCCUPATION		10. CAUSE OF DEATH		11. PLACE OF DEATH		12. TIME OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES	

1119

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

01113

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>		STREET ADDRESS (If rural, give location) <u>Cedar Lawn</u>	
3. NAME OF DECEASED (First) <u>Clarence</u> (Middle) (Last) <u>Roberts</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>9</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 9, 1893</u>
9. AGE last birthday <u>62</u> yrs. If under 1 year Months <u>7</u> Days <u>0</u>		10. If under 24 hrs. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Board of Education</u>	
11. BIRTHPLACE (State or foreign country) <u>Hill County, Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Roberts</u>		14. MOTHER'S MAIDEN NAME <u>Laura Stanbury</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>212-14-7705</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Edna Roberts Cedar Lawn, Maryland</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>420.1</u> <u>acute coronary thrombosis</u>		
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
SIGNATURE <u>J. Robert Wells M.D.</u> DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>Jan. 10 '56</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/12/56</u>	NAME OF CEMETERY OR CREMATORY <u>Edge Hill Cemetery</u>
LOCATION (City, town, or county) (State) <u>Charlestown, West Virginia</u>		
DATE REC'D BY LOCAL REG. <u>Jan. 11, 1956</u>	REGISTRAR'S SIGNATURE <u>Chas. H. Powers</u>	24. FUNERAL DIRECTOR ADDRESS <u>Suter-Houzer Funeral Home Hagerstown, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 18 1935

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

011114

1153

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 304

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>103 Franklin St Hancock</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>103 Franklin St Hancock Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>Ina</u>	(Middle) <u>Hughes</u>	(Last) <u>Robinette</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 18</u> 19 <u>56</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 22, 1872</u>
9. AGE last birthday <u>83</u> yrs.		If under 1 year Months <u>4</u> Days <u>25</u>	If under 24 hrs Hours <u>45</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Fairmount W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas A Hughes</u>		14. MOTHER'S MAIDEN NAME <u>Rhoda Wkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Emorey E Robinette 103 Franklin St Hancock</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH <u>1945</u>
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Malignancy of Breast</u>			
Antecedent cause(s) (b) <u>Arterio-sclerotic myocardial heart disease</u>			
(c) <u>Fractured femur (closed)</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>6-22-55</u>	19b. MAJOR FINDINGS OF OPERATION <u>Fracture - Hip pin operation</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, or office bldg., etc.) <u>Home</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6-18-55 P.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>Fell in Home at Fairmount W. Va.</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE S. Robert Wells MD, P.M.E. Work. Co. Hagerstown, Md Jan. 17 '56 ADDRESS Hagerstown, Md Jan. 17 '56 DATE SIGNED Jan. 17 '56

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1-17-56</u>	NAME OF CEMETERY OR CREMATORY <u>Buck Valley Christian</u>	LOCATION (City, town, or county) (State) <u>Buck Valley Fulton Penna</u>
DATE REC'D BY LOCAL REG. <u>1-17-56</u>		REGISTRAR'S SIGNATURE <u>J. A. Wells</u>	24. FUNERAL DIRECTOR <u>Howard J. Hagerman</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 24 1956

BUREAU V. S.

1120

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Washington		MARYLAND		STATE Md.		COUNTY Washington	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Hagerstown		LENGTH OF STAY (in this place) 8 hrs.		CITY (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. County Hospital				STREET ADDRESS (If rural give location) Route 5			
3. NAME OF DECEASED: (First) (Middle) (Last) Bruce Jackson Rogers				4. DATE (Month) (Day) (Year) OF DEATH: Jan 31 1956			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: Feb 2, 1892	9. AGE last birthday 63 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm-Owner		10B. KIND OF BUSINESS OR INDUSTRY: Farming		11. BIRTHPLACE (State or foreign country): Strawsburg Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Andrew J. Rogers				14. MOTHER'S MAIDEN NAME: Alberta Empswiler			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS: Mrs. Martha V. Rogers Route 5			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Myocardial Infarction						3 days	
ANTECEDENT CAUSE (S) (B) Arteriosclerotic Heart Disease						2 1/4 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4-24, 1947, to 1-31, 1956 that I last saw the deceased alive on 1-31, 1956, and that death occurred at 1:35 PM, from the causes and on the date stated above.							
SIGNATURE <i>John M. Adelly</i>				ADDRESS M. D. Hagerstown Md.		DATE SIGNED 2-1-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2-3-56		NAME OF CEMETERY OR CREMATORY Green Lawn		LOCATION (City, town, or county) Williamsport Md. (State)	
DATE REC'D BY LOCAL REGISTRAR Feb. 2, 1956		REGISTRAR'S SIGNATURE <i>Charles H. Bowers</i>		24. FUNERAL DIRECTOR Scott F. Minnich & Son		ADDRESS Hagerstown Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 6 1956

BUREAU V. S.

1121

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Washington		MARYLAND		STATE Md.		COUNTY Washington	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Hagerstown		LENGTH OF STAY (in this place) 51 years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 824 Frederick Road		STREET ADDRESS (If rural give location) 824 Frederick Road					
3. NAME OF DECEASED: (First) (Middle) (Last) Ellis Martin Rohrer				4. DATE (Month) (Day) (Year) OF DEATH: Jan 4 1956			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Specify): Married	8. DATE OF BIRTH: Sept. 15, 1904	9. AGE last birthday: 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life): Manager		10B. KIND OF BUSINESS OR INDUSTRY: Parts Dept.		11. BIRTHPLACE (State or foreign country): Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Wade H. Rohrer				14. MOTHER'S MAIDEN NAME: Lelia Unger			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No		16. SOCIAL SECURITY NO. 214-09-6522		17. INFORMANT & ADDRESS: Mrs. Rose M. Rohrer Hag. Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Acute Coronary Artery Insufficiency						5 minutes	
ANTECEDENT CAUSE (B) Coronary Arteriosclerotic Heart Disease						8 weeks	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Xanthomatosis						5 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-15, 1955 , to 1-4, 1956 that I last saw the deceased alive on 1-4, 1956 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.							
SIGNATURE Dalton M. Welty		M.O. Hagerstown		ADDRESS 1-5-56		DATE SIGNED 1-5-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan. 6, 1956		NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		LOCATION (City, town, or county) (State) Hagerstown Md.	
DATE REC'D BY LOCAL REGISTRAR Jan. 6, 1956		REGISTRAR'S SIGNATURE Charles H. Bowers		24. FUNERAL DIRECTOR Scott F. Minnich & Son		ADDRESS Hag. Md.	

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JAN 9 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1122

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01117

Dr. E. Young

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		STATE <u>Maryland</u> COUNTY <u>Washington</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		4 WKS.		Hagerstown		Hagerstown	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>PAULINE</u> (Middle) <u>A.C.</u> (Last) <u>RUSSELL</u>				(Month) <u>Jan.</u> (Day) <u>14,</u> (Year) <u>19 6</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>March 19, 1887</u>	<u>68</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>Philadelphia, Penna.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Edward A. Clegg</u>				<u>Ida Prettyman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Dr. Perley L. Russell</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
577X IMMEDIATE CAUSE (A) <u>Myocardial Failure Due to Toxiema</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						4 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) <u>Renal Insufficiency due to Operative Shock</u>						10 days.	
(C) <u>Bronchiectasis</u>						10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
<u>12.22.55</u>		<u>Massive Intestinal Adhesions.</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21h. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/5/51</u> , 19....., to <u>1.14.56</u> , 19....., that I last saw the deceased alive on <u>1.14.56</u> , 19....., and that death occurred at <u>3.05P.</u> from the causes and on the date stated above.							
SIGNATURE <u>E. Young</u> M.D.				ADDRESS (Street, city, town, state) <u>Hagerstown, Md.</u>		DATE SIGNED <u>1/16/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>1-16-56</u>		<u>Rest Haven Cemetery</u>		<u>Hagerstown, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Jan. 17/1956</u>		<u>E. Young</u>		<u>Andrew K. Coffman-Hagerstown, Md.</u>			

CERTIFICATE OF DEATH

Form No. 10

1. USUAL RESIDENCE (HOUSE OR BUSINESS)

2. TIME OF DEATH

3. PLACE OF DEATH

4. CAUSE OF DEATH

5. MANNER OF DEATH

6. SEX

7. AGE

8. RACE

9. BIRTH DATE

10. BIRTH PLACE

11. BIRTH TIME

12. BIRTH PLACE

13. BIRTH TIME

14. BIRTH PLACE

15. BIRTH TIME

16. BIRTH PLACE

17. BIRTH TIME

18. BIRTH PLACE

19. BIRTH TIME

20. BIRTH PLACE

21. BIRTH TIME

22. BIRTH PLACE

23. BIRTH TIME

24. BIRTH PLACE

25. BIRTH TIME

26. BIRTH PLACE

27. BIRTH TIME

28. BIRTH PLACE

29. BIRTH TIME

30. BIRTH PLACE

31. BIRTH TIME

32. BIRTH PLACE

33. BIRTH TIME

34. BIRTH PLACE

35. BIRTH TIME

36. BIRTH PLACE

37. BIRTH TIME

38. BIRTH PLACE

39. BIRTH TIME

40. BIRTH PLACE

BUREAU V. S.

JAN 19 1956

RECEIVED

RECEIVED

1. Name of deceased
2. Sex
3. Age
4. Race
5. Birth date
6. Birth place
7. Birth time
8. Birth place
9. Birth time
10. Birth place
11. Birth time
12. Birth place
13. Birth time
14. Birth place
15. Birth time
16. Birth place
17. Birth time
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32. Birth place
33. Birth time
34. Birth place
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36. Birth place
37. Birth time
38. Birth place
39. Birth time
40. Birth place

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Dr Welty

01118

CERTIFICATE OF DEATH

Reg. Dist. No. 302

Item 6, Film 92 2-7-56 et

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Washington</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>112 South Mulberry Street</u>		<u>112 South Mulberry Street</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last)		(Month) (Day) (Year)	
<u>Louis</u> <u>Scoropanos</u>		<u>Jan. 29.</u> <u>19 56</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>April 5, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>Restaurant Operator</u>		<u>Owner</u>	<u>Arta. Greece</u>
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
<u>John Scoropanos</u>		<u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		<u>218-30-9361</u>	
17. INFORMANT & ADDRESS		18. MOTHER'S MAIDEN NAME	
<u>Mrs. Demetra Scoropanos Wife.</u>		<u>Christina Koultouki</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease with Ventricular Fibrillation</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>Inter-capillary Glomerulo Sclerosis</u>		<u>7 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes Mellitus</u>		<u>6 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis, Obliterations of Legs</u>		<u>18 years</u>	
19a. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. HOW DID INJURY OCCUR?	
M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>1-25</u> , 19 <u>49</u> , to <u>1-29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-29</u> , 19 <u>56</u> , and that death occurred at <u>12:45 PM</u> from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>Dr. M. Welty</u>		<u>ADDRESS (Street, city, town, state)</u>	
M.D. <u>998 Potomac Ave Hagerstown Md 1-30-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Hagerstown, Md.</u>	
DATE		25. FUNERAL DIRECTOR'S SIGNATURE	
<u>Jan. 31, 1956</u>		<u>Andrew K. Coffman. Hagerstown, Md.</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1124

CERTIFICATE OF DEATH

01119

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hagerstown</u>		<u>2 days</u>		TOWN <u>Clearspring Rl</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Bernard Seibert</u>				<u>1 13 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>married</u>	<u>Aug. 15, 1888</u>	<u>67</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>farmer</u>		<u>farm owner</u>		<u>Clearspring Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William W. Seibert</u>				<u>Elizabeth Troupe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>219-34-5044</u>		<u>Mrs. Susie Seibert Clearspring, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>162X</u> IMMEDIATE CAUSE (A) <u>Bacterial endocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary abscess</u>				unknown			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Bronchiogenic carcinoma, left</u>				unknown			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>none</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>1/11/56</u>		<u>Hemothorax</u>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>October 10, 19 55</u>, to <u>Jan 13, 19 56</u>, that I last saw the deceased alive on <u>Jan 13, 19 56</u>, and that death occurred at <u>9-00 am</u>, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Adrian H. Rowland</u> M.D.				<u>Clear Spring, Maryland 1/14/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>1-16-56</u>		<u>St. Pauls</u>		<u>Hagerstown Rural Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
<u>Jan 18, 1956</u>		<u>Adrian H. Rowland</u>		<u>Adrian H. Rowland Clearspring, Md.</u>			

NOTIFICATION

1. This form is to be filled out by the physician or other person who has attended the deceased, and is to be submitted to the local health department or to the State Department of Health, as the case may be, within the time specified in the instructions. It is to be filled out in duplicate, and the original is to be retained by the local health department or the State Department of Health, as the case may be, and the duplicate is to be submitted to the local health department or the State Department of Health, as the case may be, within the time specified in the instructions.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

<p>1. NAME OF DECEASED William F. El-ore</p>		<p>2. SEX Male</p>		<p>3. AGE 50 yrs</p>		<p>4. RACE White</p>	
<p>5. DATE OF DEATH Jan 13, 1956</p>		<p>6. TIME OF DEATH 10:00</p>		<p>7. PLACE OF DEATH Baltimore, Md.</p>		<p>8. CAUSE OF DEATH Bronchogenic carcinoma, left</p>	
<p>9. MANNER OF DEATH Natural</p>		<p>10. SITE OF DEATH Home</p>		<p>11. SIGNATURE OF PHYSICIAN [Signature]</p>		<p>12. SIGNATURE OF REGISTRAR [Signature]</p>	
<p>13. NAME OF PHYSICIAN [Name]</p>		<p>14. NAME OF REGISTRAR [Name]</p>		<p>15. NAME OF WITNESS [Name]</p>		<p>16. NAME OF WITNESS [Name]</p>	
<p>17. NAME OF WITNESS [Name]</p>		<p>18. NAME OF WITNESS [Name]</p>		<p>19. NAME OF WITNESS [Name]</p>		<p>20. NAME OF WITNESS [Name]</p>	

RECEIVED
 JAN 23 1956
 BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01140

1125

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Washington</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>03 Hagerstown</u>	LENGTH OF STAY (in this place) <u>1 day</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Sharpsburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>81 Washington County Hospital</u>		STREET ADDRESS (If rural give location) <u>R.F.D. # 1</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>IDA MAE SEMLER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>January 22 19 56</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>May 15, 1894</u>
9. AGE last birthday: <u>61</u> yrs.		IF UNDER 1 YEAR: Months <u>8</u> Days <u>7</u> Hours <u>1</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Looper</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Hosiery Mill</u>	11. BIRTHPLACE (State or foreign country): <u>Washington County Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Joseph Shrader</u>	
14. MOTHER'S MAIDEN NAME: <u>Emma Everhart</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>213-24-9512</u>		17. INFORMANT & ADDRESS: <u>Harry H. Semler Sharpsburg Rt. 1 Md.</u>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>592X Cerebral Hemorrhage.</u>		<u>11 1/2 hours.</u>	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(A) DUE TO <u>Hypertensive Cardiac - Ischemic</u>	
		(B) DUE TO <u>Chronic Glomerular Nephritis</u>	
		(C) <u>17 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/21</u> , 19 <u>56</u> , to <u>1/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/21</u> , 19 <u>56</u> , and that death occurred at <u>4:05 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Walter H. Shealy</u>		ADDRESS <u>M. D. Sharpsburg, Md.</u>	
DATE SIGNED <u>Jan. 24, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/25/1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan. 25, 1956</u>		REGISTRAR'S SIGNATURE <u>Shast. Bowers</u>	
24. FUNERAL DIRECTOR <u>Suter-Rouzer Funeral Home</u>		ADDRESS <u>Hagerstown, Md.</u>	

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JAN 27 1956

BUREAU V. S.

1126

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg 1421
No. 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Washington	MARYLAND	STATE Md.	COUNTY Wash.
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Hagerstown		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Smithsburg rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Co. Hospital		STREET ADDRESS RFD #1 (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) Clara	(Middle) Ida	(Last) Smith	(Month) Jan. (Day) 7, (Year) 1956
5. SEX: female		6. COLOR OR RACE: white	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed		8. DATE OF BIRTH: April 20, 1872	
9. AGE last birthday: 83 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): house wife		10b. KIND OF BUSINESS OR INDUSTRY: own home	
11. BIRTHPLACE (State or foreign country): Frederick County		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Daniel B. Lewis		14. MOTHER'S MAIDEN NAME: Maira I. Baker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) - -		16. SOCIAL SECURITY No.: - -	
17. INFORMANT & ADDRESS: Mrs. Bertha Warner, Smithsburg, Md.			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause (a) Extensive 1st & 2nd degree burns to face, arms, chest, and thighs DUE TO			
Antecedent cause(s) (b) giving rise to the above cause stating underlying cause last DUE TO			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: Jan. 10, 1956			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home	21c. (City or town) Rural- R#1 Smithsburg, Md.	(County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Jan. 1 1956 11:30PM	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Caught self on fire while burning paper	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE J. Robert Wells M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. 1-9-56	
23. BURIAL, CREMATION, REMOVAL (Specify): burial	DATE THEREOF: 1-10-56	NAME OF CEMETERY OR CREMATORY: Wolfsville Cemetery	
LOCATION (City, town, or county) Wolfsville, Md.		(State)	
DATE REC'D BY LOCAL REG. Jan. 10, 1956	REGISTRAR'S SIGNATURE Scott F. Minnich	24. FUNERAL DIRECTOR ADDRESS: Scott F. Minnich & Son, Smithsburg	

BUREAU V. 3

RECEIVED

OFFICE OF THE ATTORNEY GENERAL
WASHINGTON, D. C.

1127

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Washington</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	LENGTH OF STAY (in this place) <u>2 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>66 Broadway</u>		STREET ADDRESS (If rural give location) <u>66 Broadway</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JOHN GORDON SMITH</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>January 10 19 56</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>March 6, 1878</u>
9. AGE last birthday <u>77 yrs.</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired): <u>Retired Conductor</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Penn. Rail Road</u>	11. BIRTHPLACE (State or foreign country): <u>Winchester, Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Robert Steele Smith</u>	
14. MOTHER'S MAIDEN NAME: <u>Anna Brown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>716-03-2070</u>		17. INFORMANT & ADDRESS: <u>Mrs. Etta Smith Hagerstown, Maryland</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebro Vascular Disease</u>			<u>2 yrs</u>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Gangrene of foot</u>			<u>4 wks</u>
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1-1-1956</u> , to <u>1-10-1956</u> , that I last saw the deceased alive on <u>1-10-1956</u> , and that death occurred at <u>11:05 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>J. D. Smith</u>		ADDRESS <u>M. D. Hagerstown Md</u>	DATE SIGNED <u>1-11-56</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1/13/56</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>
DATE REC'D BY LOCAL REGISTRAR <u>Jan. 11, 1956</u>	REGISTRAR'S SIGNATURE <u>Chas. H. Brown</u>	24. FUNERAL DIRECTOR <u>Suter-Rouzer Funeral Home</u>	ADDRESS <u>Hagerstown, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 01123
 No. 303

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>2 yrs.</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>316 W. Washington St.</u>				STREET ADDRESS (If rural, give location) <u>316 W. Washington St.</u>			
3. NAME OF DECEASED: (Type or Print) <u>BOYD</u>		(First) <u>ANTHONY</u>		(Middle) <u>SNAPP</u>		(Last)	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Feb. 5, 1896</u>	
				9. AGE last birthday: <u>59</u> yrs.		4. DATE OF DEATH <u>Jan. 30,</u> 19 <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Brakeman W. Md. Railway</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Strodsburg, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Robert Snapp</u>				14. MOTHER'S MAIDEN NAME: <u>Mollie Grady</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		(If Yes, give war or dates of service) <u>- - - -</u>		16. SOCIAL SECURITY No.: <u>314-09-2829</u>		17. INFORMANT & ADDRESS: <u>Mrs. Vallie S. Snapp</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a)..... DUE TO <u>acute coronary occlusion</u> Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO <u>inactive tuberculosis of lungs</u> stating underlying cause last (c).....				1952	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Robert H. Wells</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Jan. 31 '56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> M. D.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>3-2-56</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	
				LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Jan. 31, 1956</u>		REGISTRAR'S SIGNATURE <u>Robert H. Wells</u>		24. FUNERAL DIRECTOR <u>Andrew K. Coffman-Hagerstown, Md.</u>	
				ADDRESS	

RECEIVED

FEB 2 1956

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01124

1151

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>R#2</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>			
TOWN <u>Rural, Williamsport</u>				TOWN <u>Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Williamsport, md. R#2</u>				STREET ADDRESS (If rural give location) <u>Williamsport, md R#2</u>			
3. NAME OF DECEASED (Type or Print) <u>PAULETTE</u> (First) <u>SNOOK</u> (Last)				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>17</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>April 21, 1953</u>	9. AGE last birthday <u>2</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Washington Co. md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles E. Snook</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Doyle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>R#2 Chas. E. Snook Williamsport, md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
752X IMMEDIATE CAUSE (A) <u>Infant</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hydrocephalus</u>				Semi Burial			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>NONE</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>NONE</u>							
19a. DATE OF OPERATION <u>9-2-53</u>		19b. MAJOR FINDINGS OF OPERATION <u>Unilateral Intrauterine Fetal Death</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u></u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-21</u> , 19 <u>53</u> , to <u>1-7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-15</u> , 19 <u>56</u> , and that death occurred at <u>5:00</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Wm. A. Heest</u>				ADDRESS (Street, city, town, state) <u>314 N. Potomac St. Hagerstown, Md.</u> DATE SIGNED <u>1-18-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1/19/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
24. REC'D BY REGISTRAR <u>Jan. 20, 1956</u>		REGISTRAR'S SIGNATURE <u>Wm. A. Heest</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Inc.</u> ADDRESS <u>Wm. A. Heest, N. Pres</u>			

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Charles E. Zwick

Chas. F. Zuck - Williamsport, Pa.

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East Haven General Chapel, Conn.

Feb 4 1904 A.M.

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1. 4. 1952

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INSTRUCTIONS

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Dr Welty

01125

1129

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL or end give nearest town) TOWN <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>1 Day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown R # 5</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. County Hospital</u>				STREET ADDRESS (If rural give location) <u>Old Forge Road</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>BRUCE</u> <u>HOWARD</u> <u>SNYDER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 26 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>August 7 1907</u>	9. AGE last birthday <u>48</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman Fairchild Corp.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Clear Spring Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry G. Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Irene Bloyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>Peace Time</u>		16. SOCIAL SECURITY NO. <u>217-07-7458</u>		17. INFORMANT & ADDRESS <u>Mrs Ella Beckley Snyder</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>						<u>24 hours</u>	
2. ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) <u>Arteriosclerotic Heart Disease</u>						<u>4 years</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> N. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-25-56, to 1-26-56, 1956, that I last saw the deceased alive on 1-26-56, 1956, and that death occurred at 9:30 A.M. from the causes and on the date stated above.							
SIGNATURE <u>Dr. Walter M. Welty</u> M.D.				ADDRESS (Street, city, town, state) <u>Hagerstown Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>1-28-56</u>		NAME OF CEMETERY OR CREMATORY <u>Dunkard Cemetery</u>	
24. REC'D BY REGISTRAR <u>Jan. 30, 1956</u>		REGISTRAR'S SIGNATURE <u>Blair H. Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01126

1130

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		STATE <u>Md.</u>		COUNTY <u>Wash.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>50 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>				STREET ADDRESS (If rural give location) <u>897 W. Washington St.</u>			
3. NAME OF DECEASED (Type or Print) <u>Samuel H. Staubs</u>				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>30</u> (Year) <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Dec. 17, 1869</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>self employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real estate broker</u>		11. BIRTHPLACE (State or foreign country) <u>Washington Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Henry Staubs</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Ann Moats</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-09-9987 A</u>		17. INFORMANT & ADDRESS <u>Mrs. Charlotte Desmond Hagerstown, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3</u>	
446x IMMEDIATE CAUSE (A) <u>Ischemia</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pneumonia</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>hepatocholesterolemia</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>arteriosclerosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u> </u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>stroke</u>			
22. I hereby certify that I attended the deceased from <u>1/21/56</u> , to <u>1/30/56</u> , that I last saw the deceased alive on <u>1/30/56</u> , and that death occurred at <u>9:30</u> M. from the causes and on the date stated above.							
SIGNATURE <u>D. J. Boyer</u>		M.D. <u>135 N. Poloma St.</u>		DATE SIGNED <u>1/31/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-2-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Pauls</u>		LOCATION (City, town, or county) (State) <u>Hagerstown, Md. Rural</u>	
24. REC'D BY REGISTRAR <u>Jan. 24/1956</u>		REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraiss</u>		ADDRESS <u>Hagerstown, Md.</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF CHURCH

15. SIGNATURE OF OTHER

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BUREAU V. S.

FEB 3 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01127

1155

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY WASHINGTON	MARYLAND	STATE MARYLAND	COUNTY WASHINGTON
CITY (If outside corporate limits, write RURAL OR TOWN) RURAL HAGERSTOWN	LENGTH OF STAY (If in this place) 55YRS.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL HAGERSTOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS HAGERSTOWN RT.#6		STREET ADDRESS (If rural give location) HAGERSTOWN RT.#6	
3. NAME OF DECEASED: (First) DANIEL (Middle) M. (Last) STRITE		4. DATE (Month) (Day) (Year) OF DEATH: JAN. 27 1956	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (State) MARRIED	8. DATE OF BIRTH: 3/12/1873
9. AGE last birthday 82 rs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10B. KIND OF BUSINESS OR INDUSTRY: SELF EMP.	11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY: U.S.A.		13. FATHER'S NAME: JOHN S. STRITE	
14. MOTHER'S MAIDEN NAME: CATHERINE LESHER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (if Yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS: MR. AMOS W. STRITE HAGERSTOWN RT. 6 MD.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) 422.1 <i>Coronary Vascular Disease</i>			3 yrs
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-1-1956 , to 1-27-1956 that I last saw the deceased alive on 1-25-1956 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
SIGNATURE <i>A. W. Strite</i>		ADDRESS DATE SIGNED 1-30-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1/31/56	
NAME OF CEMETERY OR CREMATORY Millers Memorial Church Wash. Co., Md.		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR Jan 30, 1956		REGISTRAR'S SIGNATURE <i>W. H. Powers</i>	
24. FUNERAL DIRECTOR A. E. Munnich		ADDRESS Shenandoah, Pa.	

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FEB 1 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 300

1. PLACE OF DEATH:

COUNTY Washington MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Sharpsburg Md. LENGTH OF STAY 85 yrs.
 (Specify: in this place)

HOSPITAL OR INSTITUTE OR STREET ADDRESS Sharpsburg Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Washington

CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Sharpsburg Md.

STREET ADDRESS (If rural give location)
Sharpsburg Maryland

3. NAME OF DECEASED:

(First) (Middle) (Last)
Nannie Elizabeth Swain

4. DATE (Month) (Day) (Year)
 OF DEATH: Jan. 4 19 56

5. SEX:

Female

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Widowed

8. DATE OF BIRTH:

Sept. 11-1870

9. AGE last birthday

85 yrs.

IF UNDER 1 YEAR

Months 3 Days 23

IF UNDER 24 HRS.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

Home

11. BIRTHPLACE (State or foreign country):

Sharpsburg Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

Charles Smith

14. MOTHER'S MAIDEN NAME:

Rachel McCoy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

No

16. SOCIAL SECURITY No.

None

17. INFORMANT & ADDRESS:

Mrs. Adam Weaver Sharpsburg Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A) General paralysis

INTERVAL BETWEEN ONSET AND DEATH

2 weeks

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) Cerebral arteriosclerosis

DUE TO

1 year

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Senility

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E INJURY OCCURRED

While ☐ Not while ☐
at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1, 1955 to Jan. 4, 1956, that I last saw the deceased alive on Jan. 4, 1956, and that death occurred at 11: P M, from the causes and on the date stated above.

SIGNATURE

Walter H. Shealy

ADDRESS

M. D. Sharpsburg, Md.

DATE SIGNED

Jan. 7, 1956

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

Jan. 8-56

NAME OF CEMETERY OR CREMATORY

Mt. View Cemetery

LOCATION (City, town, or county)

Sharpsburg Md.

(State)

DATE REC'D BY LOCAL REGISTRAR

Jan. 7, 1956

REGISTRAR'S SIGNATURE

E. E. Brown

24. FUNERAL DIRECTOR

Albert Leaf Williamsport Md.

ADDRESS

BUREAU V. S.

JAN 9 1956

RECEIVED

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

I TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1131

CERTIFICATE OF DEATH

01129

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Penna.</u>		COUNTY <u>Adams</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>32 Months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Littlestown</u>		<u>75x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Garlock Nursing Home</u> <u>241 So. Prospect Street.</u>				STREET ADDRESS (If rural give location) <u>East King Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Margaret</u> <u>Nellie</u> <u>Tagg</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1/31/56</u> <u>19</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>October 5, 1864</u>		9. AGE last birthday <u>91</u> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife, Housework, Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Carroll County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Selby</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Delphay</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Hagerstown, Md.</u> <u>Ralph S. Tagg, 819 W. Irvin Ave.,</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
332x IMMEDIATE CAUSE (A) <u>Arteriosclerosis, General with cerebral thrombosis.</u>						<u>50/10</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture right clavicle</u>						<u>6 weeks</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/15</u> , 19 <u>55</u> , to <u>1/31</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/23</u> , 19 <u>55</u> , and that death occurred at <u>1</u> PM, from the causes and on the date stated above.							
SIGNATURE <u>Edward W. Little</u>				ADDRESS (Street, city, town, state) <u>217 W. Washington St.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/2/56</u>		NAME OF CEMETERY OR CREMATORY <u>Methodist Church Cemetery</u>		LOCATION (City, town, or county) (State) <u>Union Mills, Carroll Co., Md.</u>	
24. REC'D BY REGISTRAR <u>Feb. 2, 1956</u>		REGISTRAR'S SIGNATURE <u>Charles H. Peckers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. M. Little + Son</u> <u>Littlestown, Pa.</u>			

CERTIFICATE OF DEATH

TO BE FILLED BY THE REGISTRAR OF DEATHS

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Registrar

Signature of Physician

Signature of Coroner

Signature of Minister

Signature of Undertaker

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

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Signature of Interment

NAME OF DECEASED

AGE

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DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Registrar

Signature of Physician

Signature of Coroner

Signature of Minister

Signature of Undertaker

Signature of Burial

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DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Registrar

Signature of Physician

Signature of Coroner

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Cause of Death

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NAME OF DECEASED

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DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Registrar

Signature of Physician

Signature of Coroner

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Signature of Interment

BUREAU V. S.

FEB 6 1999

RECEIVED

NOTIFICATION

NOTIFICATION OF DEATH TO THE FAMILY OF THE DECEASED. The family of the deceased is hereby notified that the death of the deceased has been registered and that the death certificate has been issued. The family is requested to provide a copy of the death certificate to the appropriate authorities. The family is also requested to provide a copy of the death certificate to the appropriate authorities. The family is also requested to provide a copy of the death certificate to the appropriate authorities.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01130 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Washington</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
TOWN <u>Rural Hagerstown</u>	<u>6 years</u>	<u>Rural Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>R.F.D. # 6</u>		<u>R.F.D. # 2</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>LAURA A. UNGER</u>		<u>January 25 19 56</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>November 29, 1872</u>
9. AGE last birthday		IF UNDER 1 YEAR	
<u>83 yrs.</u>		Months <u>1</u> Days <u>26</u> Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
<u>Housewife</u>			<u>Missouri</u>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>William Shiflett</u>		<u>Cora ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS:	
<u>no</u>		<u>Charles H. Unger Hagerstown, Maryland</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiovascular dis.</u>			<u>Years</u>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
260X (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
<u>Diabetes Mellitus.</u>			<u>10 yrs.</u>
19A. DATE OF OPERATION:		20. AUTOPSY?	
<u>None.</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct. 12, 1954</u> , to <u>Jan. 25, 1956</u> , that I last saw the deceased alive on <u>Jan. 25, 1956</u> , and that death occurred at <u>5:40 P.</u> M, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>R. Bue</u>		<u>January 27, 1956.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Rest Haver Cemetery</u>	
DATE THEREOF		LOCATION (City, town, or county) (State)	
<u>1/28/1956</u>		<u>Hagerstown, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
<u>Jan. 28, 1956</u>		<u>Suter-Kouzer Funeral Home Hagerstown, Md.</u>	

BUREAU V. S.

JAN 31 1956

RECEIVED

1132 MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

01131

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAGERSTOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAGERSTOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>438 LIBERTY ST.</u>		STREET ADDRESS (If rural, give location) <u>438 LIBERTY ST.</u>	
3. NAME OF DECEASED (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
<u>CARL</u>	<u>WILLIAM</u>	<u>WILKINSON</u>	<u>Jan. 24</u> 19 <u>56</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JANUARY-23-1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAYOUT WORK FAIRCHILD AIRCRAFT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FAIRCHILD AIRCRAFT</u>	9. AGE last birthday <u>50</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>BOONSBORO WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM H. WILKINSON</u>		14. MOTHER'S MAIDEN NAME <u>AGNES KENDLE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>W.W.2.</u>		16. SOCIAL SECURITY No. <u>218-07-3778</u>	
17. INFORMANT AND ADDRESS <u>CALVIN W. WILKINSON HAGERSTOWN MD</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>322.0</u> Immediate cause (a) _____ Antecedent cause(s) (b) <u>acute alcoholic narcosis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____			INTERVAL BETWEEN ONSET AND DEATH
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>-</u>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>-</u>		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY <u>none</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR? <u>none</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>S. Robert Wells M.D.</u>		DATE SIGNED <u>1-28-56</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>JAN. 29, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
DATE REC'D BY LOCAL REG. <u>JAN. 28, 1956</u>		24. FUNERAL DIRECTOR <u>WM. F. BAST AND SONS BOONSBORO MD.</u>	

RECEIVED

JAN 31 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01132

Reg. Dist. No. 302

1134

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Washington		STATE Md.		COUNTY Washington			
CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown		LENGTH OF STAY (In this place) 5 weeks		CITY (If outside corporate limits, write RURAL and give nearest town) Maugansville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Carlock Nursing Home				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Jonathon Jacob Williams				4. DATE OF DEATH (Month) (Day) (Year) 1 4 19 56			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH May 14, 1872		9. AGE last birthday 83 yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY laborer		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Williams				14. MOTHER'S MAIDEN NAME Elizabeth Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Mrs. Charles Heefner Maugansville, Md			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) 422.1				Cardio Vascular Disease		5 yrs	
ANTECEDENT CAUSE(S) DUE TO				Prostate Hypertrophy		3 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-13, 1956, to 1-4, 1956, that I last saw the deceased alive on 1-3, 1956, and that death occurred at 11 A.M. from the causes and on the date stated above.							
SIGNATURE <i>Dr. E. W. Deth</i>				ADDRESS (Street, city, town, state) <i>Hagerstown Md</i>		DATE SIGNED <i>1-5-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF Jan. 8, 1956		NAME OF CEMETERY OR CREMATORY Salem Ref. Cemetery		LOCATION (City, town, or county) Cearfoss Md.	
24. REC'D BY REGISTRAR DATE <i>Jan. 9, 1956</i>		REGISTRAR'S SIGNATURE <i>Chas H Bowers</i>		25. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss Hagerstown, Md.			

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH-BALTIMORE, MD.

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

INTERMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

EDUCATION

OCCUPATION

EDUCATION

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BUREAU V. 8
JAN 12 1956

RECEIVED

JAN 8 1956

DEPT. OF HEALTH

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01133

1153

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		STATE <u>Md</u>		COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cascade</u>		<u>2 1/2</u> years		TOWN <u>Cascade</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Virginia Annette Willis</u>				<u>1 22 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Sept. 16, 1901</u>	<u>54</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		<u>House Wife</u>		<u>Cascade Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Alford Nichols</u>				<u>Jennie Wade</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>Thomas Willis, Cascade Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>153x</u> IMMEDIATE CAUSE (A) <u>Inanition</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of Sigmoid Colon with Metastases</u>				18 months			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				10 years			
<u>Ulcerative Colitis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 6, 1956</u> , to <u>1-22-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-22-56</u> , 19 <u>56</u> , and that death occurred at <u>6:15</u> AM , from the causes and on the date stated above.							
SIGNATURE <u>Ross A. Funch</u>				DATE SIGNED <u>1-23-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				ADDRESS (Street, city, town, state)			
<u>Burial</u>				<u>117 W. Main St. Washington, D.C.</u>			
DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)			
<u>1/24/56</u>		<u>Bethel</u>		<u>Fantz #1</u>		<u>Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Jan. 25, 1956</u>		<u>Geo. W. Ferguson</u>		<u>Harry J. Goss</u>		<u>Wynnesboro, Pa.</u>	

CERTIFICATE OF DEATH

MONTGOMERY STATE OF MARYLAND - BALTIMORE 18

BUREAU V. 2

JAN 25 1956

RECEIVED

John J. Jones

RECEIVED
 DIVISION OF HEALTH
 BALTIMORE, MARYLAND
 JAN 25 1956

1133

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		LENGTH OF STAY (in this place) <u>1 week</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cavetown</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Lewis Henry Wolf</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 17 19 56</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>April 19, 1894</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>electrician</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>electric shop</u>		11. BIRTHPLACE (State or foreign country): <u>Washington County, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Amos R. Wolf</u>				14. MOTHER'S MAIDEN NAME: <u>Gazella Lewis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes WW I</u>		16. SOCIAL SECURITY NO. <u>215-07-9415</u>		17. INFORMANT & ADDRESS: <u>Roscoe G. Wolf, Smithsburg, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis & Hemiplegia</u>						<u>7 days</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 10, 1956</u> , to <u>Jan. 17, 1956</u> , that I last saw the deceased alive on <u>Jan. 17th</u> , 1956, and that death occurred at <u>11:01 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Frank F. Shapp</u> ADDRESS <u>10972 R. Potomac St Hagerstown Md</u> DATE SIGNED <u>1/18/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>1-20-56</u>		NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>		LOCATION (City, town, or county) (State) <u>Smithsburg, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan. 18, 1956</u>		REGISTRAR'S SIGNATURE <u>Charles H. Gowers</u>		24. FUNERAL DIRECTOR <u>Scott F. Minnich & Son, Smithsburg</u>		ADDRESS	

BUREAU V. S.

JAN 23 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1135 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01135
 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY WASHINGTON	MARYLAND	STATE MARYLAND	COUNTY WASHINGTON
CITY (If outside corporate limits, write RURAL OR TOWN) HAGERSTOWN	LENGTH OF STAY (in this place) LIFE	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HAGERSTOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MARTIN MANOR NURSING HOME	STREET ADDRESS (If rural give location) 225 EAST AVE.		
3. NAME OF DECEASED: (First) BARBARA (Middle) ELLEN (Last) WOLFINGER		4. DATE (Month) (Day) (Year) OF DEATH: JAN. 31 19 56	
5. SEX: FEMALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH: 2/11/1881
9. AGE last birthday 74 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life.) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY: HOME	
11. BIRTHPLACE (State or foreign country): MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: ALEXANDER M. WOLFINGER		14. MOTHER'S MAIDEN NAME: SOPHIA LAMBERT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, NO or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT & ADDRESS: HAGERSTOWN MD.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) 420.0 Arteriosclerotic Heart Disease		2 days	
ANTECEDENT CAUSE (B) 002X			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Pulmonary tuberculosis (inactive)		In hospital in 1953-1954.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: Jan 31, 1956		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 30, 1956 to Jan 31, 1956 that I last saw the deceased alive on Jan. 31, 1956 , and that death occurred at 2:00 P.M. from the causes and on the date stated above.			
SIGNATURE Ra Bue		DATE SIGNED Feb 2, 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		NAME OF CEMETERY OR CREMATORY Rose Hill Cem. Hagerstown Md.	
DATE THEREOF 2/3/56		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR Feb 2, 1956		24. FUNERAL DIRECTOR W.D. Horne	
REGISTRAR'S SIGNATURE W.D. Horne		ADDRESS Hagerstown, Md.	

BUREAU V. S.

FEB 6 1936

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>WASHINGTON</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN <u>LITTLESTOWN - Rural</u>		<u>60 YEARS</u>		TOWN <u>LITTLESTOWN - Rural</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00 BOONSBORO MD. R. 2</u>				<u>BOONSBORO MD. R. 2</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
<u>ORPHA - ESTELLA ZITTLE</u>				<u>JANUARY - 2 - 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>FEMALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>SEPTEMBER - 20 - 1880</u>	<u>75-3-12</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSEWIFE</u>		<u>OWN HOME</u>		<u>FREDERICK CO. MD.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>WILLIAM HENRY KLINE</u>				<u>LUCINDA CATHERINE HALLER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
<u>NO</u>				<u>NONE</u>		<u>ALVEY C. ZITTLE BOONSBORO MD. R. 2</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma Sigmoid</u>						<u>2 yrs</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>Nov 55</u>		<u>Carcinoma Sigmoid</u>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug</u> , 19 <u>55</u> , to <u>Jan 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 31</u> , 19 <u>55</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>J. E. Harp</u>		<u>M. D.</u>		<u>Jan 3 '56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>JAN - 5 - 1956</u>		<u>BOONSBORO CEMETERY</u>		<u>BOONSBORO WASH. - Co. MD</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Jan 5 - 1956</u>		<u>John H. Ball</u>		<u>WM. F. BAST AND SONS</u>		<u>BOONSBORO MD</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 9 1956

BUREAU V. S.